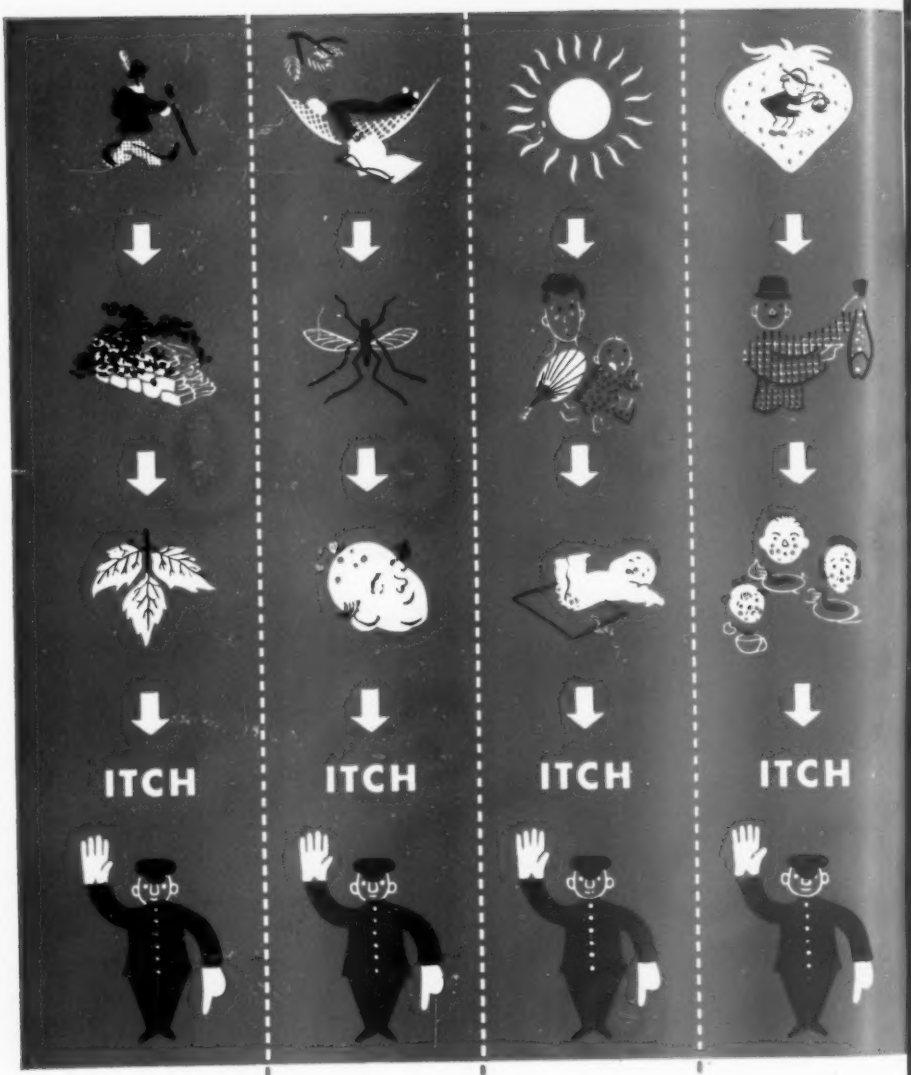

WEST NEBRASKA METHODIST H
R.N.
MAY 1949



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R.N. CONTENTS

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features

departments

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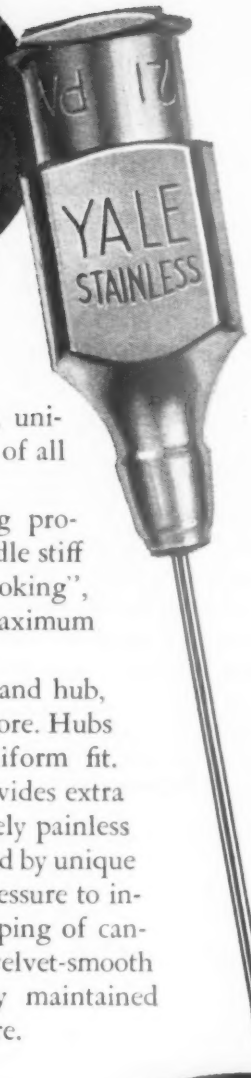

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DEBITS & CREDITS

Let's All Write

Dear Editor:

I have a friend, a nurse, who was stricken with polio last year; she is quite ill and requires a respirator.

Understandably, she is rather depressed and I am certain that a few letters from fellow nurses would be greatly appreciated and would have a favorable reaction on her frame of mind.

She may be reached as follows: Phyllis Potmesil, c/o Highland Hospital, Oakland, California.

FRANCES B. MATHEWS, R.N.
OAKLAND, CALIF.

A Good Lesson

Dear Editor:

Janet M. Geister, R.N., in "What It Means to Be a Person," [**R.N.**, Jan.], must herself be a fine mature adult who deserves appreciation and recognition for her work.

It is an excellent morale booster and builder, and should stimulate much enthusiasm for all of us to take up cheerfully our added responsibilities toward each other and humanity.

The article could be read with benefit by anybody, but since it was directed at us, I will presume we need it. I, for one, will try to put her advice into action.

"Being a person is a big job—study it," and earning a measure of maturity by "replacing emotional reactions with cerebral action," are phrases worth a second thought.

MARY VIETER, R.N.
QUEENS VILLAGE, N.Y.

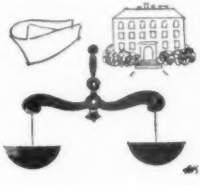
Redundant?

Dear Editor:

I was very much surprised to read of "spinal meningitis" in *Science Shorts* [**R.N.**, Dec.]. I was always taught that the word "spinal" was quite wrong and wholly superfluous when used with meningitis. What other kind of meningitis is there? Other examples of unnecessary words are: sugar in sugar diabetes (diabetes does refer to sugar) and mental telepathy (telepathy is mental). Am I wrong about this?

H. BEAUCHAMP, R.N.
SAN DIEGO, CALIF.

[*Meningitis is an inflammation of the meninges, the membranes which line the brain and spinal cord and may be qualified depending on the general site or sites of inflammation. Thus, we have spinal meningitis, cerebral meningitis or cerebrospinal meningitis. Sugar diabetes, a lay*



term, refers to diabetes mellitus, a disease manifested by sugar in the urine. Diabetes insipidus refers to a disease of different etiology exhibiting an increased amount of urine. We agree that telepathy can be used alone but the term "mental telepathy" has become so common that —well—why quibble?—THE EDITORS]

Slower Pace

Dear Editor:

After reading your editorial, "Compromise or Conversion" [R.N., Nov.], I find myself disagreeing with Mr. Graham Davis and also those who advocate a shorter training period for general and private duty nurses. A clinical nurse needs every bit of three years in order to learn and practice her nursing skills.

When I was in training, we were rushed through our subjects and we never seemed to have enough time to study because we worked on the wards between classes. How can a student concentrate on classwork when she is worrying if she mitered the corner on Mrs. A's bed correctly or if she charted her morning temperatures? In many schools, students are relied upon for most of the work on the wards. This system should be changed. Wouldn't it be a slight improvement to have part of the students work while the others have classes and vice versa? In any case, let's slow down the pace so that the student can assimilate her knowledge. It takes eight years to become a doctor and it is essential that the nurse who works with the doctor

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should receive an adequate degree of training.

I am also bothered by the fact that under the two-year plan the real nurse, the bedside nurse, would receive the least amount of training. The bedside nurse as well as the administrator or teacher needs advanced knowledge and skill to perform her nursing duties which, by the way, are not all easy, menial tasks.

VALERIE DICKENS, R.N.
ILION, N.Y.

If You Ask Me

Dear Editor:

In reply to "Legislation Needed?" in *Debits and Credits* [**R.N.**, Jan.], I would like to state an honest opinion. If this industrial nurse had worked for three years in a large plant—I mean worked out and carried on an intensive and well-planned nursing program—she would have saved her company money and would have been a necessary asset rather than a liability.

If this nurse was permitted to do first aid treatment only, then she failed by not being able to sell her company the idea of better utilization of a registered nurse's time.

Her suggestion of legislation would not be necessary if she had made herself valuable in maintaining a health program and satisfying the employes. Had this been the case, the employes would have demanded that her services be continued.

I firmly believe this case to be a

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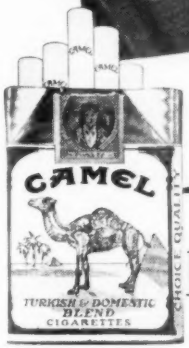

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question of more education for the individual nurse rather than legislation to cover her former employer.

R.N., PONCA CITY, OKLA.

Special Interests

Dear Editor:

I am writing to voice my disagreement with your negative stand on compulsory health insurance [R.N., Dec.]. The Government estimates between 60 million to 70 million people are financially unable to insure themselves adequately against the disaster of doctor bills. You maintain that these millions of people can accept charity, but is charity available where and when it is needed? An insurance plan such as the new version of the Wagner-Murray-Dingell bill allows these people to preserve their personal dignity and receive the fundamental requirements of medical care whenever needed. Is this not the more democratic way?

Can you give us a few facts on the "multiple dangers of nationalized medicine?" England's plan is highly successful with the general public, and, after all, that is for whom it was designed. The only ones who stand to lose by such a system in the U.S.A. are specialists who earn high incomes and drug and patent medicine concerns.

SHIRLEY M. BROWN, R.N.

BOSTON, MASS.

[R.N. *will defend its "negative stand on compulsory health insurance" to the last ditch. Mr. Oscar Ewing, not the Government, has arbitrarily estimated that 68 million*

people with incomes below $3,000 cannot insure themselves against medical bills. This figure shrinks, however, when we consider that 52 million people in all income groups are covered by health insurance of some sort, and that another 24 million get free Government medical care.

Unemployed charity patients will not be insured under the new compulsory health insurance bill (S.5). They will receive insurance benefits only if their insurance premiums are financed by both public and private agencies.

Do you really believe that with the current shortage of doctors, medical care will be available where and when it is needed? Even the bill admits that there may be certain limitations of medical service. Do you know that the bill does not provide all "the fundamental requirements of medical care?" Hospitalization is not provided for either tuberculosis or psychiatric cases—though the latter account for half of all hospital admissions each day.

"A few facts on the multiple dangers of nationalized medicine" can be culled from the experiences of other countries.

► *Government control of medicine has not contributed to high medical standards in the densely populated countries of Germany, Italy and Russia. England's system has been on trial but 10 months.*

► *Individual taxation under compulsory health insurance may eventually equal the menacing character of*

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*Citrus fruits—among the richest known sources of Vitamin C—also contain vitamins A, B, and P, readily assimilable natural fruit sugars, and other factors such as iron, calcium, citrates and citric acid.

References:

1. Gordon, E. S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947.
2. Manchester, T. C.: Food Research, 7:394, 1942.
3. McLester, J. S.: Nutrition and Diet, Saunders, 4th ed., 1944.
4. Rose, M. S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944.
5. Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, 7th ed., 1948.

FLORIDA

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medical bills. New Zealand pays its health bills with 40 per cent of Government revenue, and even that isn't enough.

► *Government control of medicine tends to limit responsibility of the community in conducting its own affairs. Pertinent question: Could health conditions among the American Indians have been improved without Government care?*

Specialists may still deservedly earn higher incomes than general practitioners under the bill. There is no reason to believe that patent medicines will lose their potent appeal to the public except through better health education. Drugs necessary for treatment may become restricted as they are in Rumania and soon will be in England because of ECONOMIC MEASURES *or* SHORTAGES. *Is this good?*—THE EDITORS]

For the Defense

Dear Editor:

I believe that the "haphazardly trained, so-called auxiliary workers or aides" to whom Louise Jerryberry refers in her letter [R.N., Dec.] are, in many cases, intelligent, conscientious and efficient workers.

I have observed a number of these aides who impressed me with their willingness and ability to work in effective cooperation with "licensed person(s) of some training." My own experience convinces me that a blanket indictment of nurses' aides is unwarranted.

MARY KAY CLEAVELIN, R.N.
EVANSVILLE, IND.

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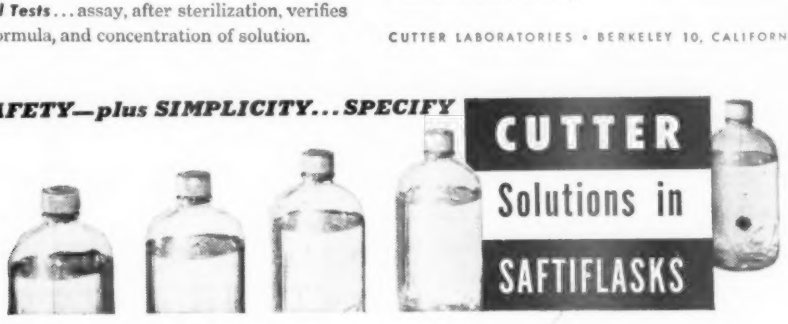

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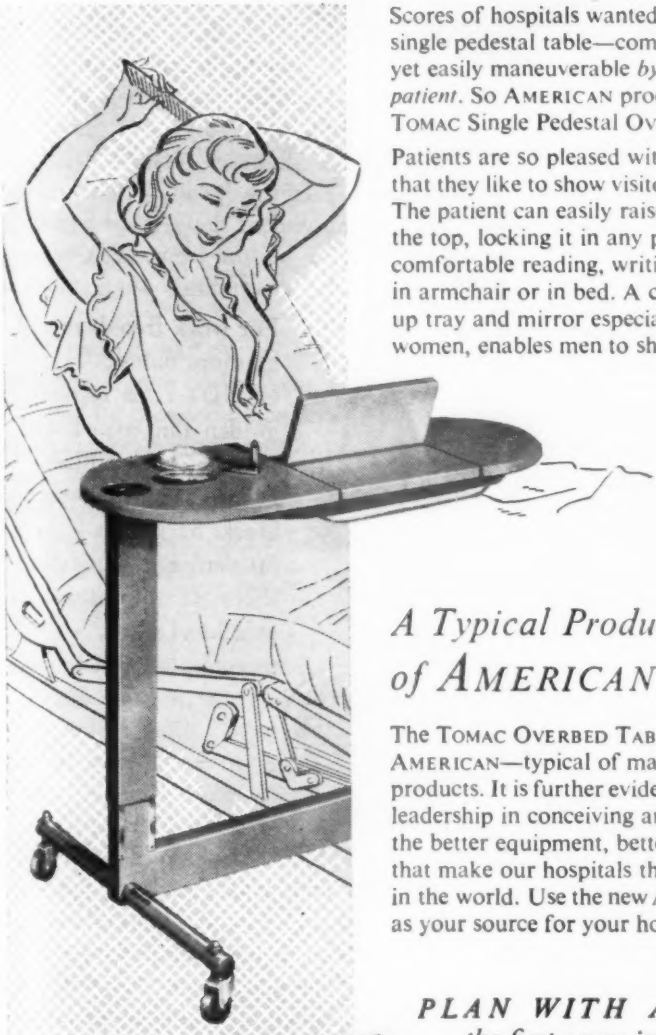

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*

Efforts to detect the estimated one million unknown diabetic cases in the U.S. will be speeded by an automatic blood-sugar testing machine now being developed by the USPHS. Blood samples of 40 persons can be tested at one time, with results available in 5 minutes.

*

A new series of spastic paralysis drugs called dioxolanes, for relief of muscle spasm in cerebral palsy, poliomyelitis and other diseases, have shown excellent experimental results in studies conducted at the University of Rochester and sponsored by National Foundation for Infantile Paralysis. Some of these compounds may supersede Myanesin, a muscle-relaxing drug, recently made available for clinical use under the proprietary name of Tolserol.

*

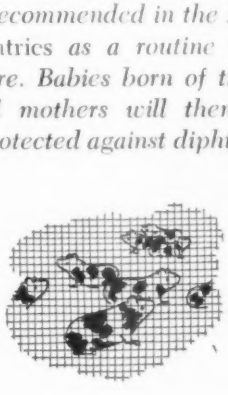
The Philadelphia County Medical Society's Study Commission reveals that an analysis of 306 postoperative deaths showed that nearly 50 per cent are preventable from the viewpoint of anesthesia. They point out that the relationship of preventable deaths to the use of various anesthetic agents is paramount while the need of trained personnel and postoperative observation rooms is also a determining factor.

*

Intravenous infusions of novocaine have proved helpful in increasing motility and relieving pain and muscle contractures of 165 arthritic patients, by anesthetizing irritated nerve endings and promoting the normal circulation needed for healing, reported Drs. David J. Graubard of New York and Milton C. Peterson of Kansas City in a recent issue of the *Connecticut State Medical Journal*. This method is solely an adjuvant to the treatment of arthritis and does not represent a "cure," as the cause of the disease is unknown.

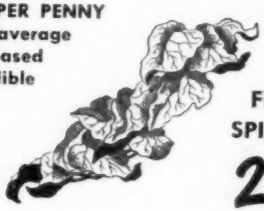
*

Diphtheria immunization for pregnant women showing positive Schick tests is recommended in the Archives of Pediatrics *as a routine prenatal procedure. Babies born of these immunized mothers will then be already protected against diphtheria.*



RESEARCH SHOWS HOW YOUR PATIENTS CAN HAVE GOOD FOOD AT LESS COST

EXAMPLE:
SPINACH PER PENNY
Following average prices all based on solid edible portion



FRESH SPINACH
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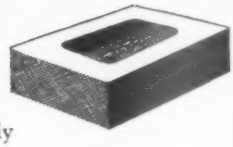
- **Full-year field check by 19 Universities* provides significant data on meeting today's living costs.**



FROZEN SPINACH
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In these days of tight budgets, don't your patients often ask: "How can I give my family good meals at prices I can afford to pay?"

SPINACH IN GLASS
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Seeking the answer, 19 leading American universities conducted a 12-months' research project—October, 1946 through September, 1947, on the COST AND AVAILABILITY of 12 commonly used Fruits and Vegetables in the four forms in which they are regularly marketed . . . FRESH, FROZEN, in GLASS, and in CANS.

The results of this comprehensive study on the 12 fruits and vegetables boil down to this: *Penny for penny, canned foods in general give consumers more food for their money, as well as more nutritional values. Most foods in cans cost less than the same foods in glass—less than fresh foods—and far less than frozen foods.*

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FREE

booklet giving full details of Comparative Cost and Availability Study. Copies of previously published booklet, "Canned Foods in the Nutritional Spotlight" are also yours for the asking.

Please send me, free of charge, ...copies of the new booklet, entitled: "Canned Foods in the Economic Spotlight." L

Name.....

Address.....

City.....Zone.....State.....

☐ Also send.....copies of "Canned Foods in the Nutritional Spotlight."

SOUND RECOMMENDATION

Results of this coast-to-coast research again demonstrate the importance of canned foods in relation to improved national nutrition. The more closely you study the known nutritional values of foods in cans, their *high* percentage of year-round availability, and their *low* cost generally, the more justified will you feel in recommending this solution to today's high cost of living.

*For full details see "Comparative Cost and Availability of Canned, Glassed, Frozen, and Fresh Fruits and Vegetables" in the April, 1948, issue of the *Journal of the American Dietetic Association.*

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Designed with that extra Barco flourish of fashion . . . note Peter Pan collar; trench tucked blouse, front and back . . . the flattering figure conforming set-in contour belt. Convenient button front. Long or short sleeves with removable shoulder pads.
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Tests in Prominent hospitals prove

Jergens Lotion

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THE TESTS

Conducted in leading hospitals and supervised by staff pediatricians.

THE PROCEDURE

Jergens Lotion and three treatments commonly used in hospitals were tested on the skins of hundreds of newborn infants. The four treatments tested were:

1. Mineral Oil
2. Soap and Water
3. Cornstarch and Soap and Water
4. Jergens Lotion

The skins were observed for a period of two weeks for incidence of rashes: macules, papules, and pustules.

THE RESULTS

Jergens Lotion gave 5 times better protection against the above skin irritations than the control treatments.

THE PRODUCT

Jergens Lotion is sterile, does *not* support bacterial growth. Active ingredients: Glycerine, Sweet Almond Oil, Spermaceti, Benzaldehyde, Gum Benzoin, Alcohol.

THE REPORT

These hospital-conducted tests indicate that you can recommend Jergens Lotion to your patients as a superior daily skin care for newborn infants.

If you have not already received your copy of the report of these Hospital tests, write to the address below and the report will be mailed to you promptly. The Andrew Jergens Company, Box 6, Dept. 78A, Cincinnati 14, Ohio.

Official U.S. Navy Photograph, Pacific Fleet

IN MEMORIAM:

Of you who died under fire at Anzio, Belgium, Germany and Okinawa
Of you who were massacred at Mt. Scopus in the siege of Jerusalem
Of you who perished in the tragic fire at St. Anthony's Hospital

OU were a slave in Homer's time, and washing the feet of a wandering beggar who sat in the hall of Odysseus, you were the first to recognize the returned master by his scars when his own wife doubted . . . In the harbor of Corinth on the Saronic gulf, where stood the pagan temple to Aphrodite, you were a Christian deaconess visiting the afflicted . . . You were a cloistered nun in the Hotel-Dieu of Paris, walking for centuries through endless corridors, serving countless patients for Christ's sake . . . You were a king's daughter, and were married to a king by Anselm in Westminster Abbey, but you put a hair shirt on your queenly body and lovingly kissed the feet of lepers and dried their wounds with your hair and built a hospital for their comfort . . . You were a Béguine of Flanders, and became known for your skillful ways with the sick . . . You were a Daughter of St. Camillus, perishing with your Order when you went to the final plague in Barcelona . . . You were a Sister of Charity of Vincent de Paul, all France was your hospital, and then your white cornettes were seen abroad . . . You were a pauper in London town, heavy and filthy and drunken, and in the absence of other employment you became an asylum nurse, but as you could not read, you asked the lunatics to decipher the labels on the medicine bottles . . . In the lost abyss of Scutari, you were the Lady-with-the-Lamp, and with the background of a vast cemetery for statistics your pity and your passion created Modern Nursing . . . You were a modern girl, and you became a trained nurse for Humanity's sake . . . In the zero hour of Democracy, you landed with the American troops, and giving sulfa drugs and plasma under fire, you died on the beachhead of Anzio . . . You were a graduate of Lincoln Hospital, for your skin was colored, and in the European Theatre of Operations you cared tenderly for German prisoners of war . . . You were an Hadassah nurse in Palestine, and refugee Jews from Poland and families of Arabs from the desert came to you for relief . . . You served at Bataan, where you had little to give the soldiers except a smile, and when the Japanese bombers blew your hospital to pieces you escaped by Clipper to Australia . . . Now the war is over, and peace has come again, but Mother Earth, sick and hungry and tired, awaits your healing hands . . .

"Dedication: To the Nurse" from *White Caps, the Story of Nursing*, by Victor Robinson, M.D., J. P. Lippincott Co., Philadelphia, 1946.

CANDID COMMENTS—ON

WHEN A DOCTOR reaches 60 he is in his prime. No one thinks he must now give up practice and start raising roses. His 60th birthday is simply another milestone in his progress. Though naturally he has shortened his working day, his life is full and active, one that demands physical as well as mental energies.

With the nurse it is different. Nursing has been notable for its early retirements. Only a few decades ago private duty nurses who for the most part made up the profession, were often told that their professional life expectancy was about fourteen years. "According to the 1930 Census," wrote Dr. May Ayres Burgess,* "most trained nurses are young. Seventy-one per cent are less than 35 years old. About 1 per cent are 65 or older. . . . The average professional life of a graduate nurse is 17.34 years."

Today the race is still to the swift and strong. The attitude still prevails that age is a primary factor in determining a nurse's usefulness. In the end, of course, it does matter but not nearly so early as of yore, for conditions have changed greatly. But we have no clear cut place for the nurse whose feet aren't so good in the marathon of getting the work done. While the war brought out many "aged" nurses, their abilities to adapt quickly to new ways and to swing into action were considered phenomena rather than perfectly natural events.

At the war's end, while many of the "aged" nurses returned to their private lives, a goodly number stayed on, pleased with their ability to "take it" and fascinated by the interesting trends in patient care today. And this marked the beginning—but only the beginning—of a better break for the older nurse. "Age is no factor in employability today," says the director of one of the largest nursing services in the country. "We have a number of nurses over 65 who are worth their weight in gold." This director does not bow to custom but judges the nurse by more important criteria than age. Another says, "Anyone with two hands and feet is welcome. I ask about age simply for the records." She, in turn, seems to think only in terms of today's needs: "pressures are so great we'll use anyone who can navigate without a wheel chair."

When the pressures finally subside, what then? Over and above this

*Nursing Schools—Today and Tomorrow, 1934.

ON THE OLDER NURSE

by Janet M. Geister, R.N.

question is one of a clear cut policy in relation to the older nurse. Our trouble is not that older nurses can't get *some* kind of job today. It is that we have no philosophy or plan for utilizing their skills and knowledges effectively and usefully. Until we do develop these things we are overlooking a rich source of power, and ignoring the right to work of a splendid band of people.

The older nurse, like the older industrial worker, is the victim of outmoded thinking. A counselor reports, "It's still the unusual employer who says 'age makes no difference. I want a nurse who can handle the job.'" Many employers still stick to the old pattern of demanding "someone who is under 50," a pattern established when conditions were greatly different from those of today.

Early nursing with its 24-hour duty, its household tasks, its failure to provide even the commonest health protections for the nurse, took heavy toll. In 1927 when I studied the ANA Relief Fund rolls I was shocked to find that the greatest single cause of incapacitation was tuberculosis, and this largely among new graduates. While today's health protections for students still have gaps, they are much superior to those of the past. And graduate nurses, exposed to the public health movement, are much more keenly aware of the values and methods of protecting their health.

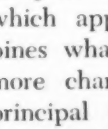
The shorter day, the long weekends, sick leaves, vacations, all largely absent from the earlier scene, help to change the pattern. Nursing is still hard work. The changed character of medical practice probably packs more activity into the 8-hour day than was present in the 24-hour one. Nurses still get tired, but not completely "bushed" as of old, and there is more time to recuperate in between shifts. It seems very evident today that nursing offers considerably more years of productive work than in the past.

The idea in industry that a man over 45 can no longer be safely and productively employed, originated before our present-day industrial-health and safety programs were established. Though industry learned during the war that older workers are valuable, the trend since then is to cut off the worker over 45. But facts revealed by the health and safety programs are blowing the old prejudices and old ideas to smithereens. A small but growing group does its hiring on the basis of what a man *can* do, rather than on what he *cannot* do. [*Continued on page* 52]

ONE EMBLEM for ALL NURSES?

by Eleanor Flexner and Frances Lewis, R.N.

What emblem would you choose as being truly symbolic of nursing? The Nightingale lamp, Linda Richards, designs involving the caduceus, or some form of the cross? The field is wide open to suggestions, for as yet the nursing profession has not adopted or advocated the use of one over-all emblem, although other professions possess such identifying emblems. The architects have an octagonal shaped pin issued by the American Institute of Architects, bearing the date of its founding. The accepted emblem of the AMA is the staff of Aesculapius. The American Hospital Association has an emblem which appropriately enough, combines what it conceives to be the more characteristic insignia of its principal personnel: the staff, the Nightingale lamp, and the Lorraine, St. George and Pattee crosses.



The favorable response given by nurses to commercial manufacturers of pins with tricky R.N. designs, and car emblems, would seem to indicate a need for adoption of an official emblem—one that could be employed only by registered professional nurses and one that need not be used solely with the uniform.

The designer of this future official emblem will not have to look outside the profession for his inspiration. Nursing has a rich and varied collection of symbols with historical significance, as shown by its wealth of hospital pins and national and state seals and emblems.

The registered nurse is still chiefly identified by her hospital cap and pin. School pins are as varied as the human imagination has been able to contrive them. Some are well-designed and a credit to the profession through their effective use of such historic symbols of nursing as the cross, the caduceus and the lamp of Florence Nightingale. Others are tortured monograms or bare and unimaginative groupings of initial letters which add nothing to the stature of the profession they should enhance.

A survey of 100 nursing school pins made some years ago at Michigan University Hospital in Ann Arbor revealed that 92 schools used some form of the cross. The cross first became a symbol of nursing among the great knightly orders which were founded during the Crusades for the dual purpose of fighting to regain the Holy Sepulchre from the infidels, and car-

ing for the wounded and sick as a work of God. Since nursing has always been closely associated with the churches of all faiths, the use of the symbolic cross persists until today.

The most common form of cross found in connection with nursing is the regular or St. George's cross. It was worn in white by the Knights Hospitaliers to signify the purity of life required of those who fought in defense of the Christian faith and who served the poor and suffering. This cross appears on innumerable school pins. The Swiss flag shows it in white on a red background. This flag with the colors reversed became in 1864 the emblem of the international Red Cross in deference to the wishes of its Swiss founder, Henri Dunant, who proposed that all members of the Red Cross Society should wear the red cross on a white background to distinguish them as neutral workers in wartime; in peacetime the workers would prepare materials and train volunteer nurses. The American Red Cross Nurse's emblem was adopted in 1906 and adapted from a button of the American Medical Association, but the outside band was in the form of a wreath instead of a plain band, and the wording "American National Red Cross Nurse" encircled the red cross.*

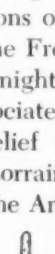
Another cross which appears frequently on hospital pins is the Cross Pattee, also used by the Knights Hospitaliers. Its broad arms symbolize the wings of a bird covering her young, thus showing the protecting power of those bearing the symbol. Today the cross appears on the pin of St. Luke's Hospital Nursing School in San Francisco, Lutheran Hospital in Cleveland and others. The Johns Hopkins' pin, traditionally accepted as the Maltese Cross, in actuality resembles the Cross Pattee with curved arms.

The true Maltese Cross, which is a distinctive variation of the Cross Pattee, has indentations which form eight distinctive points, symbolic of the eight beatitudes arising from the four Christian virtues: prudence, justice, temperance and fortitude. The Maltese Cross was the emblem of the Knights of St. John of Jerusalem, later the Knights Templars. Their emblem has been handed down to St. John's Ambulance Corps of present-day Great Britain, and appears on the pins of Lewis-Gale Nursing School in Roanoke, Va., and Genesee Hospital in Rochester, N.Y. A third order of knights who participated both in fighting and nursing were the Teutonic Knights, who wore a black habit and white cloak with a black cross embroidered in gold.

An emblem familiar to all of us is the double-barred cross on the Christmas seals of the National Tuberculosis Association, but its history is probably known to few. The upper bar

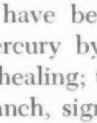
*Exclusive use of name and emblem of American National Red Cross is protected by Act of Congress, approved in 1905.

represents the board placed by Pilate's order over the head of Christ when He was crucified. The cross derives its name of Cross of Lorraine from the fact that it was adopted as a symbol by the first Christian king of Jerusalem, Godefrey de Bouillon, Duke of Lorraine. During the Nazi occupation, it became known to millions of Americans as the symbol of the Free French. It was used by the Knights Templars, and has been associated through the ages with the relief of the needy. The Cross of Lorraine appears on the emblem of the American Hospital Association.



The staff is the symbol most closely associated with medicine, and is in the center of the insignia of the American Medical Association. It also appears on the pins of the nursing school of University Hospital, Baltimore, Md., and Beth Israel in Newark, N.J. All Greek statues of the physician-god Aesculapius show him with a stout knotted staff around which winds a tightly clinging snake. The stoutness of the staff permitted the sick and lame to lean on it; the knots signified the knotty problems of illness; the snake was the mythological symbol of healing and of the renewal of youth and the prolongation of life.

Another emblem that has come down from antiquity and become associated with nursing is the caduceus, which is found on the pins of many nursing schools: Virginia Mason Hospital in Seattle, Wash., Highland Sanitarium in Shreveport, La., and others. It consists of a wand or slender staff around which are coiled two snakes; at the head of the staff are two outspread wings. The staff is supposed to have been given to the winged Mercury by Apollo, god of the art of healing; the wand is from an olive branch, signifying peace; the snakes indicate wisdom, or the authority bestowed on Mercury by Apollo.



The caduceus came to be connected with medicine quite arbitrarily, when the Swiss printer, Johannes Froben (1460-1520) placed it on the title page of medical books. The first individual physician to adopt it was Sir William Butt, physician to Henry VIII of England, and others followed his example. In 1912 the AMA rejected the caduceus in favor of the staff of Aesculapius, but it is still found in the insignia of the Army Medical Corps and the United States Public Health Service where it is combined with a fouled anchor to indicate that organization's earliest duty—the care of sick and injured seamen. The USPHS insignia was adopted by the United States Cadet Nurse Corps during World War II, which also used the Maltese cross as an arm badge.

The Nightingale lamp is a dramatic symbol associated with modern nursing, although it is highly problematical whether any of its manifold likenesses bear resemblance to the camp lamp Florence Nightingale actually carried

through the grim hospital wards at Scutari. The emblem as it appears on the AHA insignia and the pins of such nursing schools as East Orange General Hospital, N.J.; Broadlawn in Des Moines, Iowa; Northeastern in Philadelphia, Pa.; West Nebraska Methodist, Neb.; and others, is probably a merger of the Nightingale legend with the traditional "lamp of knowledge" or "wisdom."

In reviewing nursing organization emblems, we find a less varied assortment. We also note a confusion in nurses' minds regarding the difference between a seal and an emblem. Actually a seal is not an emblem but a wax, wafer or paper impression of an identifying character affixed to official documents, originally used in lieu of a signature. Most organizations, however, call the emblems on their stationery letterheads, seals. These as well as the true seals always bear the date of the incorporation of the organization.

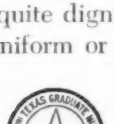
Of the six national nursing organizations, the NOPHN is the only one searching for a real emblem at the present time, one that "would be simple in outline, could be adapted for many uses and would come to have a special meaning to the public as do the symbols of other community service . . ."* The NOPHN already has a "seal," presented to it on its inception as an organization in 1912 by its predecessors, the agencies of the National Conference of Visiting Nurses. The seal depicts the figure of a woman planting and watering a young tree. The Biblical inscription reads "When desire cometh it is a tree of life." Pins with this design are currently available through one jeweler and must be authorized by the national office.

The "seal" of the AAIN has the white cross of St. George as background for the smokestacks of a factory. It was designed by Harriet Hartford and Mary Noonan, both industrial nurses of Boston, Mass. It may be used by any local, state or regional branch of the AAIN on approval of the headquarters' office.

The ANA "seal" was adopted in 1915 and is designed about the figure of America's very first professional nurse, Linda Richards. The year 1873 at the top of the seal indicates the year when Miss Richards graduated from a hospital in Boston and the establishment of the first three schools of nursing in this country at New York, New Haven and Boston, based on the Florence Nightingale system. The date at the bottom, 1897, represents the year in which the ANA was incorporated. In the motto surrounding the picture "Service-Efficiency-Humanity," "Efficiency" appears in the center of the seal. The state associations of North Dakota, North Carolina, Tennessee and Illinois have adopted this same seal but interestingly enough they have put "Humanity" in the center instead of "Efficiency." [*Turn the page*]

Public Health Nursing, May 1948.

A number of state associations have recognized the need of an emblem with wider significance than the pin received from a school of nursing. The California State Nurses Association at one time sold its pin to nurses possessing certificates of current registration. However, the practice was discontinued in 1939 because there were too many cases of fraud. Lost or stolen pins were resold, and worn either by persons who were not bona fide R.N.'s or by nurses who had failed to renew their annual registration. A similar situation occurred in Oregon, which prior to 1942 also provided its nurses with pins. The Ohio State Nurses Association offers its pin today for sale to nurses currently registered in the state. In a badge or bar form, it shows sheaves of wheat stacked before a range of mountains behind which the sun is rising. The Association does not consider this a state emblem and does not want to adopt it officially, because of the possibility of its being stolen and used by non-nurses, and because it does not seem "quite dignified enough" to use on a uniform or as an emblem for a car.

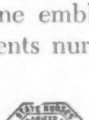


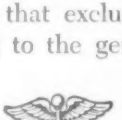
Other associations have a chevron which is worn on the sleeve. Michigan's is a blue cross in a gold circle, surrounded by the words "Michigan Registered Nurse." Texas has its state emblem of a five-pointed star on a blue circle with "Texas R.N." encircling it. New York supplies an arm badge for both outdoor and indoor uniforms.

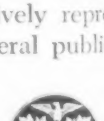
Many of the state associations possess only "seals" which serve as emblems chiefly on letter-heads. Colorado and New Jersey have the so-called Nightingale lamp. Indiana uses the Cross of St. George with the word "Memor" meaning mindful. Puerto Rico's "seal" is the ancient Cross Pattee with the motto "Servicio-Fraternidad." Pennnsylvania and Georgia have "seals" with no apparent nursing tradition.

Some states use symbols with local or historical associations: Texas—the Lone Star; New Hampshire—its famous landmark, the "Old Man of the Mountain"; Maine—the pine tree, selected in 1940 and used by the different district associations with change only in date of their incorporation. Florida's "seal," which depicts the map of Florida in a triangular motto of "Private Duty"—"Institutional"—"Public Health," was adopted in 1935 and designed by two Miami nurses, Dorothea B. Pinder and Elizabeth Van Wagner.

Surveying the emblematic field of nursing we can see that there is no one emblem that exclusively represents nursing to the general public.







The wide number of symbols and designs used by nursing groups today, and the limited use to which they are put, seem to befog instead of clarify the status of the nursing profession. [*Continued on page* 82]

RN REPORTS:

AAIN Annual Conference

"INDUSTRIAL NURSING is the application of the principles of nursing in business and industry, to meet the needs of the worker by helping him to develop and maintain the highest potential level of health and efficiency through prompt remedial nursing care of the ill and injured; health and safety education; and cooperation with all plant departments and the utilization of community services."

This is the definition accepted by the 580 industrial nurses representing 38 states, including Hawaii, South America, Canada and the District of Columbia, attending the American Association of Industrial Nurses' Seventh Annual meeting at the Book Cadillac and Statler Hotels in Detroit, Michigan, April 3-9.

Created in 1942, the AAIN is the youngest of the six national nursing organizations, but by no means the least vocal. Mutual problems peculiar to this specialized branch of nursing brought the Association into being and these same problems are holding it together. When the Vermont Marble Company employed their first industrial nurse in 1895, little did they realize the significance of their act. Preceding the establishment of the AAIN, industrial nurses sought answers to their problems by forming sporadic industrial nurses' clubs. Eventually these clubs combined into joint conferences throughout the country, and it was inevitable that the next step would be that of organizing their own autonomous national association.

Recognizing its youth and inexperience as a national organization, the AAIN has struggled valiantly for survival these past seven years. It believed guidance and leadership should come from the national organization but the local application should be the prerogative of each local area. Its members knew that within their own Association they would find the understanding and advice they sought. They were convinced they were a distinct specialty in nursing even though others thought this a debatable point. Through their own initiative and with a persevering educational program this conviction has been strengthened, with the result that the basic skills necessary to industrial nursing have been improved considerably and will continue to be improved. That AAIN's policies are determined by nurses, all of whom are active in [*Continued on page* 64]

Anticoagulants and Hemostatic Agents

■ THE FORMATION of an external blood clot is essentially a protective device. It keeps us from bleeding to death. On the other hand, the formation of a clot within the body may block off a vitally needed blood supply and lead to paralysis or death.

There are several physiological explanations of the mechanism of blood clotting, but the following one seems to be generally accepted. The pro-clotting factors of the blood consist of fibrinogen, a soluble protein, calcium ions, prothrombin and thromboplastic substances. The latter, released from crushed tissue cells, platelets or thrombocytes, and blood corpuscles, is able to neutralize the anti-clotting factors, antithrombin and antiprothrombin (heparin) which normally prevent clotting of blood within the vessels. Prothrombin by the aid of calcium ions produces thrombin, which in turn changes the soluble protein, fibrinogen, to insoluble fibrin. Fibrin, a network of needle-like fibers, forms the basis of the clot and in its meshes are caught the red and some of the white blood cells. As this fibrin clump shrinks and solidifies, it exudes a fluid called serum, which is simply plasma minus fibrinogen.

The formation of the blood clot within the blood vessels is likely to occur when the vessel lining becomes mechanically injured by surgery or inflamed by bacteria or their toxins. In these cases the altered endothelial cells of the injured blood vessel may act as an irritant and set off the clotting process. A sluggish flow of blood at this point also allows the thromboplastic substances from the disintegrating cells to effect the formation of thrombin and a consequent clot or thrombus. If the thrombus is loosed from its mooring on the vascular wall, it becomes a traveling thrombus or embolus, capable of obstructing the arterial, venous or capillary blood flow.

Doctors have long realized that patients can "clot to death" as well as bleed to death, but up to a few years ago they had no ready weapons to combat the clotting dangers present in operative procedures and certain vascular diseases. They now have access to two important anticoagulant drugs, Dicumarol and heparin.

Dicumarol was first recognized as the substance in spoiled sweet clover responsible for hemorrhagic disease in cattle. It was later synthesized and adopted for clinical use because of its ability to restrict prothrombin production in the liver and thus reduce the potential coagulability of the blood. Dicumarol is usually given in preference [*Continued on page* 56]

by Frances Lewis, R.N.

MOTHER of NURSES

Whene'er a noble deed is wrought,
Whene'er is spoken a noble thought,
  Our hearts in glad surprise
  To higher levels rise.

The tidal wave of deeper souls
Into our inmost being rolls,
  And lifts us unawares
  Out of all meaner cares.

Honor to those whose words or deeds
Thus help us in our daily needs,
  And by their overflow
  Raise us from what is low.

Thus thought I, as by night I read
Of the great army of the dead,
  The trenches cold and damp,
  The starved and frozen camp . . .

The wounded from the battle-plain
In dreary hospitals of pain,
  The cheerless corridors,
  The cold and stony floors.

Lo! in that house of misery,
A lady with a lamp I see
  Pass through the glimmering gloom,
  And flit from room to room.

—Henry Wadsworth Longfellow

DRUG DIGEST

DICUMAROL N.N.R.

(Anticoagulant)

PROPRIETARY NAMES: Dicumarol (collective registered trade mark of Wisconsin Research Foundation)

PHARMACOLOGY: Dicumarol, synthesized from salicylic acid, is believed to act as an anticoagulant by inhibiting the production of prothrombin, one of the important clotting factors manufactured in the liver. It is used in prevention and treatment of postoperative thrombosis, pulmonary embolism, coronary thrombosis with myocardial infarction, thrombophlebitis and rheumatic heart disease with multiple embolization. It is contra-indicated in hepatic diease, vitamin C or K deficiencies, renal insufficiency, blood dyscrasias, purpura, ulcerative lesions and recent surgery involving the central nervous system.

DOSAGE: Prothrombin time is usually determined before any day's administration. The first day's dose is usually 200 mg. to 300 mg. with doses ranging from 100 mg. to 200 mg. thereafter. It is dispensed in capsules of 50 mg. and 0.1 Gm. for oral use. Because it takes 24 to 48 hours to act, producing its maximum effect in 3 to 5 days, heparin may be given during this latent period.

UNTOWARD ACTIONS: Patient should be watched carefully for signs of hemorrhage which may occur in subcutaneous tissues, gums, nose, urinary tract and recent operative wounds. Because Dicumarol is extremely potent and its effects cumulative, dosage may be determined by daily prothrombin blood tests. In case of hemorrhage, blood transfusions and vitamin K therapy will be indicated.

HEPARIN SODIUM N.N.R.

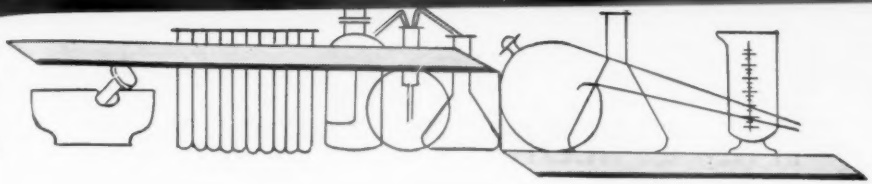
(Anticoagulant)

PROPRIETARY NAMES: Liquaemin, Heparin/Pitkin menstruum.

PHARMACOLOGY: Heparin sodium, a water-soluble powder obtained from ox tissues, is thought to prevent intravascular clotting by preventing the formation of thrombin from prothrombin. Although heparin cannot dissolve clots already formed, it has been used effectively in preventing and treating thromboembolic conditions. Its use is contra-indicated in blood dyscrasias, potential bleeding lesions, and renal or hepatic diseases because of danger of hemorrhage. Anticoagulant therapy is usually started with heparin in addition to Dicumarol because of the former's more rapid action.

DOSAGE: Heparin is standardized biologically by 100 units per mg. of powder. It is available for I.V. injection in 10 cc. vials, each cc. containing 10 mg. sodium heparin. It may be given by continuous I.V. drip, usually 150 mg of heparin to 1,000 cc. of saline or dextrose solution; by intermittent I.V. injections of 50 mg. q. 4 h.; and by subcutaneous injections of heparin in slowly absorbed media such as Pitkin menstruum which must be warmed before injection, or peanut oil and beeswax. Dosage can be more carefully controlled by the continuous infusion method.

UNTOWARD ACTIONS: Hematoma of joints, epistaxis, hematuria, subarachnoid hemorrhage or other forms of hemorrhage may occur with excessive heparin dosage and should be treated by blood transfusions and vitamin K. Clotting time must be determined frequently during heparin therapy.



MENADIONE U.S.P.

(Vitamin K Therapy)

PROPRIETARY NAMES: Aquakay, Chola-K (bile salts and menadione), Kappaxin, Kayklot, Kayquinone, Kolklot, Menaquinone, Thyloquinone—oil soluble. Hykinone, Kappadione, Synkamin, Synkayvite—water soluble.

PHARMACOLOGY: Vitamin K plays an important part in the liver's production of prothrombin, a vital factor in the blood clotting process. The absorption of vitamin K depends on the presence of bile salts and fat in the intestine. Synthetic forms of vitamin K are given therapeutically to raise low prothrombin blood levels in newborn babies, patients with obstructive jaundice, biliary fistula and ulcerative conditions of the intestines. It is useless in extensive liver damage. Pregnant women may be given vitamin K directly before or during labor in order to protect baby.

DOSAGE: Average dosage for adults is 1 to 2 mg daily. Bile salts 0.3 Gm. to 0.6 Gm is often given concurrently with oral doses of vitamin K. Menadione Sodium Bisulfite, the water soluble form of vitamin K may be administered by I.M. or I.V. injection. Average daily dosage ranges from 1 to 5 mg. Large doses of 72 mg. in 10 cc. may be given slowly (1 cc. per minute) by I.V. injection to counteract untoward effects of Dicumarol or heparin therapy.

UNTOWARD ACTIONS: Overdosage may produce leukopenia. Daily 2 mg. dosage should rarely be continued longer than a four-week period. Prothrombin clotting time tests are usually made to determine the extent of vitamin K therapy.

VITAMIN P THERAPY

PROPRIETARY NAMES: Hesperidin Methyl Chalcone (with or without vitamin C), Hesperidin-C, Medicitrin (hesperidin and eriodictyol glycoside), Pev-gram (hesperidin), Rhamnotin (rutin, ascorbic acid), Rucevitin (rutin, ascorbic acid), Pecegram (hesperidin, acorbic acid). (This list does not include rutin preparations containing aminophyllin and phenobarbital.)

PHARMACOLOGY: Vitamin P was first discovered in 1926 by a Hungarian, Szent-Gyorgyi. The vitamin was called P for paprika, a substance which seemed to lessen capillary permeability and check bleeding more effectively than vitamin C. The active fraction of this vitamin P was later extracted from lemon juice and called citrin, which is a mixture of hesperidin, eriodictyol and quercitrin. Hesperidin is usually used with vitamin C to control capillary permeability. When citrin's other factor, quercitrin, is hydrolysized it breaks down to quercetin. Rutin, a quercetin glycoside, helps to decrease capillary fragility in hypertension, thrombocytopenic purpura, diabetic retinal hemorrhage and telangiectasia.

DOSAGE: All vitamin P preparations are administered in oral form. Average dosage is determined by type of preparation used. Average dosage of rutin is 20 mg. three times daily, although this dosage may be increased to twice this amount with no apparent ill effects. Vitamin P therapy is usually taken until capillary fragility index becomes normal.

UNTOWARD ACTIONS: None reported as yet.

THE CHILDREN'S PHYSICIAN

Dr. Hattie E. Alexander, whose years of research finally resulted in the discovery of an antiserum for the dread influenzal meningitis.

THIS YEAR MARKS the 100th anniversary of the first woman who fought prejudice and scorn to receive a medical degree in the United States and to establish a notable career in medicine. Women doctors, following Elizabeth Blackwell's gallant, pioneer example, have, in this past century, come into their own. One of these remarkable women physicians is Dr. Hattie E. Alexander, nearly unknown to the general public.

A graduate of Johns Hopkins Medical School in 1930, Dr. Alexander today is Associate Professor of Pediatrics at the College of Physicians and Surgeons, Columbia University, New York City. She is con-

sidered by many authorities to be one of the foremost women physicians in the United States. While "Dr. Hattie," as she is affectionately called, attended the children's wards of the large New York hospitals, she stood helplessly by and watched many children succumb to the apparently unconquerable influenzal meningitis and vowed that she would find a cure for it.

Dr. Alexander knew the agent responsible—a bacillus called Hemophilus influenzae type b which causes 95 per cent of all influenzal meningitis. This organism, a small pleomorphic and aerobic gram negative bacillus, was discovered in 1892 by Richard Pfeiffer, a German bacteriologist, who recovered it from the sputum of influenza patients. Although the causative organism of influenza itself has since proved to be a

filtrable virus, H. influenzae can be a secondary invader sometimes complicating influenza and other respiratory diseases. In fact, during the influenza epidemic of 1918, H. influenzae was frequently isolated in the lungs of influenza victims.

When the organism, H. influenzae, is encapsulated, it is an important primary agent in pyogenic infections occurring in infants and children. Influenzal meningitis is one of the most serious sequellae of respiratory infections caused by H. influenzae. These organisms pass to the blood stream and finally localize in the membranes of the brain and spinal cord. Because children have a small

Eljay

by P. H. D. Sheridan

amount or none of the bactericidal antibodies in their blood, they are much less resistant to the bacterial invasion. Without specific therapy virtually all of these children died.

Dr. Alexander's particular problem was to find an antiserum for this type of meningitis, powerful enough to kill so virulent a bacillus, yet not too strong to administer to an infant. In 1906, famed Dr. Simon Flexner of the Rockefeller Institute had succeeded in combating cerebrospinal meningitis in adults with a serum, and later an anti-meningitis horse serum was perfected, but influenzal meningitis in children was still a stumbling block to researchers. Top-flight scientists sought the answer. Dr. Alexander, because her life's work and love centered around children, went into the laboratory and worked with rabbits in an attempt to discover a satisfactory treatment for the fatal disease. The growth and preparation of suspensions of the bacteria for intravenous injections of rabbits were important factors in the production of an efficient antiserum. A quantitative chemical method for measuring antibodies permitted a quantitative approach. Finally in 1939, after hundreds of experiments and patient research, Dr. Alexander modestly announced in a scientific journal that the rabbit's serum contained antibodies sufficient to incite immunity against H. influenzae type b, and yet safe enough to use for babies.

This major achievement did not terminate the doctor's research nor that of other workers who, encouraged by her success, began to widen their activities in this field of therapy. More effective than the use of antiserum alone was its use with sulfadiazine. With this therapy, the mortality dropped from over 95 per cent to 20 per cent. After Waksman and other researchers showed the marked action of streptomycin on a number of bacteria, the action of this antibiotic against H. influenzae in the test tube and mouse was investigated, and then used in the treatment of influenzal meningitis with excellent clinical results. Dr. Alexander herself now advocates streptomycin in conjunction with sulfadiazine for most patients. However, in severe cases where neurological examination indicates cerebral injury, she recommends use of all three therapeutic agents. [*Continued on page* 72]

Phot-O-pinion

The fifth in a series of exclusive pictorial reader-interviews on issues of interest to the nursing profession.

Question:

Do you agree that: (1) Practical nurses should be educated in public adult and high schools under the Vocational Educational Division of Office of Education, affiliating with hospitals for clinical experience only? (2) Practical nurses should be trained in the ratio of two to every one professional nurse? (3) The American Nurses Association should promote legislation for Federal aid to practical nurse education as well as professional nurse education?

Phot-O-pinion

Oneita Krause, *Staff Nurse, VNA, Burlington, Vermont.*

«(1) I believe that practical nurses could be educated in public schools under this division, provided such schools were needed by the community; of sound organization; offered teaching facilities of high quality; and were approved by the State Board of Nurse Examiners or other legally authorized accrediting body.

«(2) No, I do not agree that practical nurses should be trained in the ratio of two to every one professional nurse, although I do agree that there is a need for both kinds of nurses since the total nursing needs of the people have never been met satisfactorily. Each can make their own particular contribution to the better care of the sick, each maintaining a real school in every sense of the word, each maintaining standards set by a recognized body, each graduating students who are well prepared to work together. Mandatory licensure should be recommended for *all* who nurse for hire.

«(3) I agree that the ANA should promote legislation for Federal aid to both practical nurse and professional nurse education if hospitals are to be staffed adequately in the future.»

Agnes S. Wyss, *Superintendent of Nurses, Weld County Public Hospital, Greeley, Colorado.*

«The educating of practical nurses should be as much a part of high school education as the teaching of any other vocational subject. The need in the country at this time is so great that there is no alternative left. In my mind the ratio of two to one is too high. I would say three practical nurses to every two professional nurses. Again this is a public education program or should be.»

Mildred L. Mankin, *Private Duty, Portland, Oregon.*

«(1) Public adult and high schools are not adequately equipped to teach the practical side of nursing.

«(2) No, because hospital standards must be maintained at a high level.

«(3) I don't believe in extending Federal aid to practical nurses because of the difference in the standards and qualifications between the two groups.»

Clarice Dobbins, *Pediatric Supervisor, St. Margaret's Hospital, Montgomery, Alabama.*

«(1) I think that high schools and any other type of school that wishes to go forward in nursing education should encourage students to become registered professional nurses by offering proper courses in sciences, mathematics, and social studies which would be helpful. Practical nurses could also benefit from the same preliminary studies, but I think they should be trained under the same type of program as are registered professional nurses, in hospitals, and similarly should be required to register under State Board of Nursing laws.

«(2) Except from the standpoint of nursing in homes and assisting in doctors' offices, etc., it would be impractical to have twice as many practical nurses as professional nurses.

«(3) I would not approve of young high school graduates becoming practical nurses if they can become registered professional nurses. However, those who wish to do practical nursing should be given ample education before they attempt to nurse. Therefore, the ANA should aid both groups.» [*Continued on page* 70]

REVIEWING THE NEWS

▶ FEDERAL AID for medical and allied education has been proposed by Senators Pepper, Murray, Humphrey and Neely in a new bill, S. 1453. Under this plan, for each of the next three years, schools of medicine, dental hygiene, nursing, public health and sanitary engineering would be eligible for Federal grants provided they are public or nonprofit institutions, do not discriminate on out-of-state, racial or religious grounds and are approved by the Surgeon General after consultation with the National Council on Education for Health Professions which will include leading authorities in these educational fields. Total payments to any school other than a three-year diploma school of nursing would not exceed 50 per cent of the annual costs of instruction.

Payments of $200 for each student up to the school's average past enrolment and $1,200 for each one over that average would be made to nursing schools that provide basic or advanced training leading to a nursing degree. Three-year diploma schools would receive $200 for each student enrolled in the first year of training, $150 for each in the second year, and $50 for every third-year student. State funds totaling $15 million would also be appropriated for the year beginning July 1, 1949 and annually thereafter, for the purpose of maintaining an adequate practical nurse training program under the auspices of the State Boards for Vocational Education and the Commissioner of Education of the Federal Security Agency.

Although approving the bill in principle, the ANA Legislative Committee is drafting recommendations for specific changes in an attempt to amend the bill's undesirable features. If not successful, the ANA may submit its own bill.

▶ A CANCER LANDMARK may have been reached by the recent discovery of a "simple, cheap and reasonably sure blood test for cancer" which promises to diagnose the disease in its early stages. The test, which evolved from research by Professor Charles B. Huggins, Dr. Gerald M. Miller and Dr. Elwood V. Jensen at the University of Chicago, is based on the deficient coagulative ability of the blood serum of cancer patients. It was discovered that the blood serum of cancer patients coagulated much less readily upon heating and dilution than normal serum and that smaller quantities of iodoacetate (a chemical substance which inhibits coagulability of serum by heat) were needed to check the coagulation of cancer serum. An index was drawn up showing the relative inhibitive power which iodoacetate imparts to the blood. Tests on almost 300 persons--cancer patients, normal

individuals and patients with non-cancerous diseases—showed a low index or positive result in blood samples from cancer patients and also from patients with tuberculosis and massive acute infections. Samples from healthy individuals were negative. The American Cancer Society has already started to distribute information on this test to cancer clinics throughout the nation.

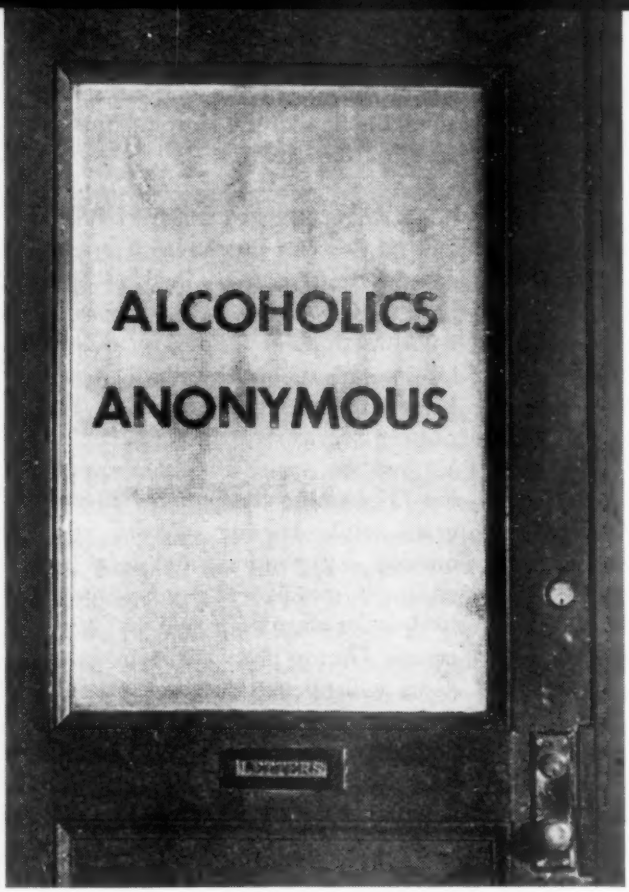
▶ LEGISLATIVE VICTORY for mandatory Nurse Practice Act in New York State! NYSNA has advised hospitals, who fought for postponement of the Act because of insufficient personnel, to set up hospital teams of registered nurse, practical nurse and auxiliary workers, in order to maintain efficient operation.

▶ A BIPARTISAN COMEBACK to compulsory health insurance is the new voluntary health insurance bill, S.1456, introduced by Senator Lister Hill of Alabama. This bill would provide medical and hospital care for the indigent through Government supported membership in non-profit, prepayment health insurance programs. It recommends extensive survey and improvement of diagnostic centers, clinics, mental, tuberculosis and chronic disease hospitals, and rural medical care facilities. The program would be entirely controlled by state agencies in conjunction with a state council on hospital and medical care, composed of medical and lay representatives from various regions of the state. Federal funds would be contributed on the basis of per capita income in the various states along the lines of the Hospital Survey and Construction Act.

▶ AMERICAN STUDENT NURSES will be honored on the 15th of this month by churches, medical and hospital associations. This occasion will directly follow the May 12 celebration of National Hospital Day and Florence Nightingale's birthday. The nursing services of the USPHS, the VA and the Armed Forces are assisting in planning the nationwide program while nursing schools, state nursing organizations and local recruitment groups will pay homage to students at church services and other events. During the week, senior students will fill out questionnaires indicating their interests in special fields of nursing; this information will later be tabulated and released on a national and community basis.

▶ ABOUT PEOPLE: *Lona L. Trott*, director of Red Cross nursing service for the Midwestern Area and author of the Red Cross textbook on home nursing, has received a scholarship for four months' study of Red Cross

[*Continued on page* 63]



Wallace Litwin

ALCOHOLICS ANONYMOUS was founded less than fifteen years ago by an alcoholic named Bill who had lost health, job and family through drinking. Today its members number 80,000 and the organization claims that 75 per cent of the alcoholics who have really tried have been rehabilitated.

Bill found his formula for sobriety in the advice of an old friend who also had a weakness for alcohol. Putting aside the current view of alcoholism as a moral depravity, he insisted that it was a disease, just as much as diabetes or tuberculosis.

As the first step in his own rehabilitation, Bill had to acknowledge that, unlike many normal people, he could not handle alcohol. He had to leave it absolutely alone, making no compromises with beer or wine. Next, he had to talk the situation over frankly with some friend, even to the extent of making a public confession, and then do what he could to repair the harm he had caused. Above all, he must look to a superior power to implement his resistance against taking that first drink. Bill proved the formula for himself and came out of the ordeal a new and an immensely happier man, on fire to spread the good news of sobriety among other alcoholics. In Akron he won his first disciple and together they started the movement called Alcoholics Anonymous.

It is not as anonymous as it used to be, but the original spirit is still with it. An organization practically without organization, a club without dues, a fraternity open to men and women alike, regardless of race or creed or politics or social position or profession, a society which demands of its members nothing save

by Rev. J. B. McAllister, Ph.D.

the sincere will to master their weakness for alcohol, the group has flourished beyond its founders' wildest expectations. Although the program has crystallized into the famous 12 steps and membership has soared, Alcoholics Anonymous has kept its simplicity and multiplied its zeal for rescuing alcoholics and keeping them sober.

Too often the mistake is made of confusing alcoholics with sots, dishevelled men and women, nuisances to the police as well as to the public, frequenters of the courts who occasionally live off taxpayers' money under the custody of the law. True, some alcoholics eventually act out every tragic detail of the popular picture of the drunk. But not every drunk is a drunkard in the sense of being an alcoholic.

A man can use alcohol quite freely, indeed too freely, even be intoxicated more or less frequently and yet not be truly an alcoholic. On the other hand a man can be just as truly an alcoholic without making a public spectacle of himself or exhibiting the classic conduct of inebriates.

Were it possible, it would be better to discard the term "alcoholic," which is too tied up with drunkard, and substitute the phrase "compulsive drinker." No matter how definitions of alcoholism may vary, alcoholics have this in common: they cannot stop drinking; their drinking interferes with normal living.

Yet, since there is no such thing as a typical alcoholic, more exact definitions must always allow for individual differences. Dr. Robert Carroll offers what seems a functionally good definition. The hour that a man "turns to alcohol as a necessity when facing the physically or mentally disagreeable, or uses it as an escape from unpleasant reality, that person has become a drunkard—not a sot but an addict. He has turned from fight to flight, from rational assimilation of the difficult to self deception."*

This definition seems operationally good because it distinguishes between a man merely drunk who can get over it and go about his affairs quite normally and the man who cannot tolerate alcohol, whose first drink means a binge, who boasts he can "take it or leave it alone" and who proves his boast by always and helplessly *taking* it. He might be called allergic to alcohol—but only figuratively.

For as the Yale studies amply show, alcoholism is not an allergy in any medical or strict sense of the word. Let us not essay an amateurish diagnosis of alcoholism but admit at once that in itself it is not simply a disease, not in itself a cause, but the unfortunate effect of psychological conditions, combined perhaps with some physical elements. If this is kept in mind, alcoholism may be called an allergy, since the term conveniently emphasizes rather significant elements which the compulsive drinker shares with the victims of allergies.

Alcoholism, or compulsive drinking, cannot be cured in the sense diseases and illnesses sometimes are. A man

*Dr. Robert Carroll, *What Price Alcohol*, p. 155, Macmillan, 1941.

cannot get over his alcoholism so that he can ever drink normally again, for alcoholics seem to have passed their tolerance point; one drink starts the alcoholics on a drunk.* However, *alcoholism can be arrested.* An alcoholic can live a life of sobriety and like it. Whatever be the intricacies of alcoholism, the alcoholic remains an alcoholic but need not be a drunkard. That has been proved by the high percentage of "dried up drunks" as they call themselves, in Alcoholics Anonymous, as well as in the outstanding work of such groups as the famous Yale clinics.

A man may be obviously a compulsive drinker to everyone but himself. All that he holds precious in life and beyond may be slipping from him down the alcoholic chute. This he may even acknowledge and yet refuse to admit his weakness. To the uninitiated this confession of weakness and need for help may seem too self-evident to be stressed. But it isn't. Indeed the man or woman who makes it has already taken a decisive step toward sobriety. Only the experienced know how slow and difficult the task often is of wringing this admission from the stubborn and deluded alcoholic. A broken arm speaks for itself. The sufferer readily admits it and seeks a physician. Not so the alcoholic. He is likely to resent bitterly the suggestion that he cannot "take it or leave [*Continued on page 76*

*To make it easier for alcoholics to forego that "first drink," A.A. puts abstinence on a short-term basis. Members are asked not to drink for 24 hours; at the end of that period not to drink for another 24 hours; and so on.

Probie

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Typical nurse's uniform 1902

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GRIFFIN ALLWITE

Candid Comments

[*Continued from page* 31]

The Federation Employment Service reports state and government studies that ended in the conclusion "that older workers when compared with their juniors were as productive, more experienced, more conscientious, less distracted and absent less frequently." They found that "Experience, Loyalty, Skill—Come with Age."* The studies revealed too that older workers suffered fewer industrial accidents and that age did not diminish efficiency except in jobs with heavy physical demands.

As the American people press their demands for more health care, we are faced with even graver nursing shortages. Some leaders believe the answer in the main must come through the help of practical nurses. Others count on larger student bodies, and some put their faith on both. Why not work just as hard to get more effective use of the supply we already have on hand, including the older nurse? It is just as great folly to cut her off from maximum usefulness because of birthdays as it is to cut off the industrial worker.

What does the older nurse offer? The credit side is heavily weighted. She has judgment, a quality beyond price, that is gained only through experience. She has stability; her values are established and she does not reach for the moon. She is adaptable. The changes in medical practice are constant and startling; the nurse who has stayed on the job has had to *learn* on the job. She has a deep respect for human life, born out of familiarity with it, and a regard for the standards of care that go into its preservation. She has a rich knowledge of people and what makes them tick. She has special and seasoned knowledges and skills.

It is no coincidence that when we nurses have illness or surgery ourselves we like to have an old timer about to turn us, to evaluate symptoms, to guard our lives. It takes more than a willing heart, a good head and a strong back to safely turn the cardiac, the pneumonia, the newly operated. It takes someone

*Slogan of this "free, non-sectarian guidance and placement agency [which] devotes primary attention to persons who have the greatest need for vocational service."

who *knows*. It takes wise eyes to recognize when physical signs have meaning.

On the debit side the older nurse may be too set in her ways. We are all allowed a certain quota of "sotness" but too much limits our usefulness. But the need for constant adjustments in nursing practice today keeps the number of rutted nurses at a minimum. Administrators sometimes have great trouble with the faithful old nurse who won't admit she is a day over 16 in her ability to get around. She stubbornly resists transfer to work with lesser physical demands and therefore limits her own opportunity for creating something new. There is the nurse too who limits her reading and study to a pinpoint. We find her in every age group where she is her own worst enemy. *There is no age limit in study and learning.* If we want to go on being useful we must go on making ourselves *more* useful.

Some older nurses do not have the educational backgrounds needed for some jobs today. There is still plenty of territory outside of those jobs if we will but search it out. Never in history has nursing had so great a variety of occupations as now. And as we rate "educational deficiencies" let's not under-rate the educational values of nursing itself. The things nurses learn in their constant battle with death and disease won't total up into college credits but college credits are only a tangible method of counting up certain acquirements. There are plenty of "old" nurses without a college credit to their names, yet they have acquired the very thing which college credits are designed to give—an ordered philosophy of life.

"People who think of a nurse as worn out at 60 think only of bedside nursing on hard cases," says a job counselor. "Why place a 60-year-old where 25-year-old energy is required? There are other ways to use her. We placed one nurse in a doctor's office to help him manage his plan of work for the day. She *knows* what he is up against and she is doing superb work. We've placed others in industries where judgment is a prime factor, especially in the night shifts where the physical work is lighter but the responsibilities

heavy . . . Older nurses need counseling, *good* counseling."

A nurse educator says, "I consider my experience in 'refreshing' retired nurses during the war, one of the high points of my life. Their alertness, eagerness, ability to adjust quickly, their judgments and skills, so quickly restored, were a constant delight and surprise to me. I came in to teach them, but they also taught *me*." And a private duty nurse adds, "Give me time for thought and I'll give you a dozen ways in which the older nurse could be used effectively. Right now I can think of her as hospital admitting officer. She knows you can't place a pneumonia next to a surgical patient. She knows lots of things that would be useful in that position."

Most people like to work and most of us are at our best when we are needed. But we resent awfully "boondoggling"—jobs created simply to give us something to do. We want work that draws on our capacities, work that dignifies us and that we can dignify with our best, work that is productive and essential. We want to be placed according to our abilities and not sidetracked because of our disabilities.

We are steadily becoming an older nation with millions surviving into their 70's and 80's. Shall all the wonderful years after 50 or 60 be spent in puttering about the yard or crocheting pot holders? Shall all the judgment, experience and wisdom of ripened people simply rust into the grave? Happily our society is becoming aware of the sheer folly of such waste. Nurses are among these surviving millions. Our replenishments of young nurses are falling short, our tasks are growing larger. Do we intend to let these older nurses drop out from sheer exhaustion because they were wrongly placed, or peter into innocuous desuetude by way of jobs made for them? Our intelligence and wisdom are on trial.

It's interesting to note that a nurse, Anna of Osloja, was knighted with the Order of the Heron in 1211 by Denmarkian Count Olaf of Krissel. (She saved his 11-year old son with her nursing skill, after he'd fallen from a horse.)

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Anticoagulants

[*Continued from page* 38]

to synthetic heparin, its anticoagulant companion drug, because it may be administered orally and because it produces a longer action. However, since it does not take effect until the already existing blood supply of prothrombin has been depleted—usually from 24 to 48 hours—heparin is generally given in addition to tide the patient over Dicumarol's latent period of action. One of Dicumarol's disadvantages is the fact that its use requires a daily prothrombin clotting time test—a test that many laboratories are not equipped to make.

Either the Quick test or the Link-Shapiro modification may be employed to determine the blood's supply of prothrombin. In the former, oxalated plasma is mixed with an equal volume of thromboplastin solution to which calcium chloride solution is added. The time from the addition of the calcium to the formation of the clot determines the prothrombin clotting time. The Quick normal prothrombin time is about 12 to 20 seconds. Dicumarol therapy to be effective usually produces a prothrombin time ranging between 30 to 50 seconds according to the Link-Shapiro modification of Quick's one stage method.

The action of the drug heparin, a synthetic form of the heparin normally present in the body, is probably due to the fact that it prevents the formation of thrombin from prothrombin. Evaluation of individual

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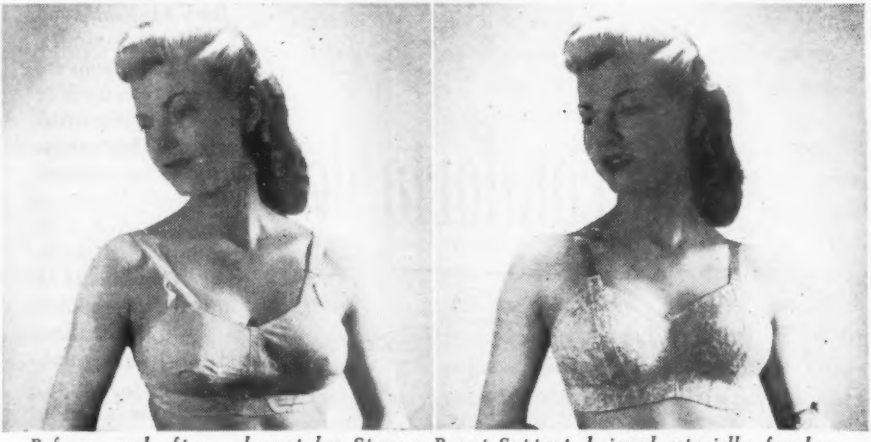

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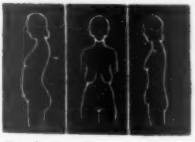

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heparin therapy is generally determined by the Lee-White clotting time test which measures the clotting time of a sample of the patient's venous blood. For best results, clotting time by the Lee-White method during heparin therapy should be kept three times the normal time of 6 minutes.

There are certain disease conditions in which a prolonged prothrombin time must be reduced. Hemorrhage from hypoprothrombinea or a low prothrombin content in the blood may be caused by a deficient absorption of vitamin K. Vitamin K, normally supplied in the average diet, depends on fat and bile salts for its proper absorption by the intestine. After absorption it is carried to the liver where it stimulates production of prothrombin. Therefore, when vitamin K is lacking as sometimes happens in the newborn or fails to be absorbed because of absence of bile salts in obstructive jaundice, it must be given in drug form to raise the prothrombin level of the blood and check bleeding tendencies.

Thrombocytopenia, a disease characterized by a decreased number of blood platelets, and by hemorrhages into the skin and mucous membranes, has been treated by intravenous injections of toluidine blue or protamine sulfate, although this form of therapy is still in the experimental clinical stage. The theory has been advanced that thrombocytopenic patients have an increased heparin activity which can be neutralized by these two agents.

Bleeding tendencies are also present in hypertension, purpura and telangiectasis, a condition marked by abnormal capillary dilatation. The increased capillary fragility found in these cases, which accounts for the bleeding tendency, can in many cases be lessened by rutin or other forms of vitamin P. Ascorbic acid (vitamin C) may also help to strengthen weak capillary walls.

Patients with hemophilia, a hereditary disease transmitted only to males by the gene of females, show an unusually long clotting time. This condition is probably due to an abnormal stability of the platelets which do not readily break down to release thromboplastin. Latest clinical treatment of hemophilia consists of transfusions of whole fresh blood, fresh or frozen human plasma and the antihemophilic fraction I of Cohn. The latter was developed during World War II by Edwin Joseph Cohn and associates at Harvard University Medical School, who succeeded in fractionating human plasma into various blood components. The fraction used in treatment of hemophilia is rich in fibrinogen.

Although it is a moot point whether internal hemorrhages can be controlled effectively by oral or parenteral administration of thromboplastic substances, there are several of these preparations on the market. Coagulen, Hemostatic Serum, Thrombin, Thrombol, Fibrogen, Koagamin, Neo-Hemoplastin, and Thromboplastin are some of the proprietary drugs used to prevent surgical or gastric and esophageal bleeding. Some of these drugs mentioned may

also be used topically to control capillary oozing and bleeding in epistaxis, dental surgery and other surgery.

Snake Venom Solution which activates prothrombin may be used subcutaneously for treatment of nose bleed, thrombopenic purpura and hemorrhage from minor surgical procedures. Stypven, containing viper venom, is employed locally to control oozing in tonsillectomy and dental extraction.

Local hemostatic packing agents play an important part in modern surgery. Oxycel, an oxidized cellulose in the form of gauze packing, turns dark brown on contact with the bleeding surface. After exerting its hemostatic effect, it softens to a jelly-like substance capable of being absorbed by the tissues. Another absorbable hemostatic packing called Gelfoam, an artificial substitute for fibrin, is prepared from specially treated gelatin solution. Saturated with saline or thrombin solution, and placed in the wound, it can be absorbed within four to six weeks. Fibrin Foam which resembles a white sponge is soaked with thrombin and pressed on the bleeding surface until clotting takes place; then it is left to be absorbed by the tissues. It helps to control bleeding from tumor beds, lacerations and traumatic wounds. All of these hemostatic agents serve to accelerate the clotting process—a vital step in the healing of wounds.

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[To facilitate clipping, the drug article, in the future, will not appear on the reverse side of Drug Digest. Also, since some drugs listed in the Digest have various uses, they will be classified according to the therapy under discussion.—THE EDITORS]

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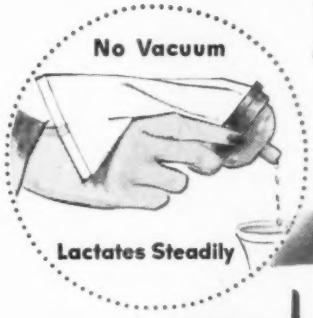
say doctors and nurses who have supervised the feeding of thousands of babies this new way...



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News

[*Continued from page* 47]

activities in Switzerland, France and Spain . . . Dorothy Doyle, sister of Mrs. Mabel K. Staupers, first nurse executive of the National Association of Colored Graduate Nurses, is the first Negro nurse to enter the State Department's Office of Inter-American Affairs. She has left for a two-year assignment in Brazil to teach nursing and midwifery and set up public health centers. Miss Doyle, a graduate of Mercy Hospital School of Nursing, Philadelphia, holds a B.S. degree from Teachers College, Columbia University, and has recently completed a course in Nurse Midwifery at the Maternity Center Association in N.Y.C. During the war she served with UNRRA in China in the capacities of acting Regional Public Health Nurse, nursing consultant and medical supply officer . . . *Mary M. Roberts,* for 27 years the competent editor and editor-in-chief of the *American Journal of Nursing,* has retired . . . *Ruth Addams* has been appointed Deputy Director of the VA Nursing Service following the resignation of *Matilda E. Dykstra,* who is now attending Teachers College, Columbia University . . . *Lt. Mary C. Grimes* (NC) USNR has been appointed chairman of the newly created Army-Navy Nurse Corps Section of the Association of Military Surgeons . . . *Edward L. Bernays,* self-styled Number One publicist of America, has been given his walking papers by the ANA. Reason given, financial; reason suspected, dissatisfaction . . . *Martina S. Nelson,* superintendent of nurses at the West Nebraska Methodist Hospital, Scottsbluff, Neb., was honored at the dedication and naming of the new nurses' home — Nelson-Ladely Hall.

▶ STATES RIGHTS are recognized in the national health bill introduced by Senators Taft, Smith and Donnell. Under their plan, Federal grants totaling $1,955,000,000 over five years, to be matched by states, localities and hospitals on a 50-50 basis, would provide medical services for the indigent. Grants would be authorized for school and public health services, hospital construction, and for maintaining and increasing medical school enrolment. The bill would also create a national health agency in the Executive branch of the Federal Government.

▶ NEWSLINGS: National Council of Catholic Nurses has appointed committee to provide plan whereby Catholic nurses would give some voluntary nursing service each year to the sick poor . . . "Call 4-3341, and receive confidential advice by the VD clinician at the City Health Department," press and radio urged Little Rock, Ark., citizens in an unusual VD control program . . . Pioneering Sydenham, first voluntary, interracial hospital, has finally succumbed to financial crisis and been temporarily taken over by N.Y.C. . . . The Nebraska legislature is the first to register state opposition to compulsory health insurance.

R.N. Reports

[*Continued from page* 37]

industrial nursing, has been an expedient to its growth.

Cognizant of the fact that a nursing specialty is only as progressive as its leaders and teachers, the AAIN's emphasis has been upon professional standards and education. Better and more specialized preparation for the industrial nurse has become its motto. Its Professional Standards Committee reported that it is preparing a guide for use of local groups in developing their own personnel practices and policies. Its Committee on Education recommended to the general membership at this conference that in order to produce standards for a program of study that will be acceptable to the unified accrediting body, that:

"1. A program of industrial nursing education as an area of specialization leading to a baccalaureate degree be recognized as the future objective for industrial nursing.

"2. In this program provision should be made for shorter periods of study, which will carry credit toward the baccalaureate degree rather than toward a certificate, and nurses entering industrial employment be encouraged to continue their educational preparation as early as it is possible to do so.

"3. In view of the limited number of students, and even more limited number of prepared faculty members, efforts should be directed toward the development of only a few, but very good programs, rather than encouraging a larger number, which would be necessarily less effective.

"4. The AAIN secure funds for four scholarships for graduate study to prepare instructors."

These recommendations, which were pointed out to be in keeping with the present trends in nursing education, were all approved after some discussion by the delegates. The discussions revealed the understandable fears of a group that (for the most part) had created a specialty with the assistance of experience only and were uneasy that this experience might not be given credit in future planning. Nurses who have

engaged in industrial nursing in small and large plants over a period of 19, 25 or 29 years might well enjoy the added prestige of a B.S. at the end of their names, but it is unlikely that they will learn anything in university courses that they don't know now about industrial nursing.

A more lively discussion period in one of the two business meetings, and therefore a more dramatic one from the reporting angle, took place when the subject of collective bargaining for industrial nurses was introduced. However, in the future of the AAIN the decisions made concerning more thorough education of tomorrow's industrial nurses will, if the reporter may chance a prediction, have a more lasting influence than will the Association's stand on collective bargaining.

It is unfortunate the motion "that the AAIN go on record as approving the ANA Economic Security Program in its entirety" was overwhelmingly voted down by the membership, for this action as it stands does not give a clear picture of the true situation.

To understand this it is necessary to go back to the discussion that took place at the ANA Biennial last June, when the Industrial Nurses' Section of the ANA wanted to go on record as objecting to the endorsement of any form of activity that might be considered to be collective bargaining. The clause in the recommendation voicing this objection was voted down by the ANA House of Delegates. It was obvious then, and more so a year later, that the house of delegates did not understand the industrial nurses' reasoning in this matter. Although those promoting the ANA Economic Security Program state that "professional nurses reject strikes and other coercive methods as inconsistent with their obligations to patients and the public," nevertheless, the term "collective bargaining" is interpreted by management in industry as "unionism."

Since its inception, AAIN has made continuous progress in working with management groups, informing them of what the industrial nurse is capable of contributing if her position is understood and supported by

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management. Not only does she administer remedial nursing care to the ill and injured, but the industrial nurse does and can do much in the way of making for better industrial relations between the worker and management.

The majority of AAIN members sincerely believe that for the nurse in industry to engage in collective bargaining is a mistake, for it would destroy her unique position, the position she and her Association have built up for her, and would doubtlessly lessen her contribution to industry considerably.

This reporter believes sincerely that when the industrial nurses voted against approving the ANA Economic Security Program in its entirety, that it was not an expression of opposition, but an expression that industrial nurses feel qualified to handle their own affairs and, more than any other group, know better the attitudes surrounding their specialty.

No one definitely knows whether the collective bargaining tactics of those state nurses' associations employing them will in the long run benefit the professional nurses in those states, or boomerang, destroying professional relationships in their wake. Because one group of nurses chooses to stay free of such an experiment *will not make or break the program.*

Two topics of discussion which, although taken up separately, eventually merged, were the legality of standing orders and malpractice insurance for the industrial nurse. It was brought out that much of the controversy about standing orders stems from terminology alone. Industrial nurses, following standing orders left by an industrial physician or medical director, may frequently be put in the position of making tentative diagnoses on their own before carrying out standing orders. Miss F. Ruth Kahl, of the U.S. Public Health Service, suggested that a term such as "medical direction for care of patient" might be a substitute for the extremely controversial "standing orders."

Litigations filed against industrial nurses who presumably thought themselves protected when carrying out standing orders were cited. Miss Ruth Eiserman, Industrial Nursing Consultant, Bureau of Industrial Hygiene, Department of Public Health and Welfare, Ohio, stated that according to that state's law, if an R.N. has standing orders and has used reasonable care in carrying out the doctor's orders, she is protected against possible charges of practicing medicine.

Mrs. Lena Lyons of New Jersey stated that in her state the nurse is protected if she is working under a full-time medical director, for then he is responsible, *but* she is not protected, and is therefore responsible for her own actions, if working under a part-time doctor.

The question of whether the Association could investigate the possibility of a reliable company underwriting group malpractice insurance for members was referred to the Policy Committee.

Limitation of space makes it im-

possible to do justice to a resume of the excellent program speakers' comments. For completely holding the audience's attention through luncheon, banquet and breakfast meetings, orchids are due Miss Lucile Petry, Chief, USPHS, Nursing Division, Mr. Frank Rising, Mr. Edgar Guest, and Dr. Kenneth McFarlane. It isn't often that every guest speaker is a success, nor is it commonplace to have America's best loved poet reciting his own poetry at breakfast. A special corsage is due Miss Melinka Herc, R.N., Assistant Professor of Nursing, College of Nursing, Wayne University, for her exceptional talk as a participant in the panel discussion on Medical Relations in Business and Industry at the Joint Scientific Program. If ever a speaker captured an audience, Miss Herc did.

New members are the life blood of any association, and their number gives an indication of the growth and progress of the organization. AAIN reports a membership gain of 756, with 68 of this number reinstatements. Below is a chart to illustrate more graphically the membership distribution in a few industrial states. This chart compares the estimated state census with the state membership and that membership is computed on a percentage basis.

State	Present AAIN Membership	USPHS Estimates of Nurses Employed in Industry	Percentage of AAIN Members
New Hampshire	46	47	97.9
Maine	43	49	87.8
Rhode Island	71	93	76.3
New York	392	637	61.5
Massachusetts	403	759	53.1
Georgia	66	140	47.1

Industrial nurses are eligible for membership in four organizations, the AAIN, the Industrial Nurses' Section of the ANA, the Industrial Nurses' Section of the NOPHN (although this Section is not too active, it is still in existence), and the Industrial Nurses' Section of the National Safety Council.

It may be confusing for an industrial nurse to have four groups interested in her. However, because of this, she should never feel alone. Guidance and advice are hers for the asking. No nurse needs to enter industry unprepared.

—Alice R. Clarke, R.N

Phot-O-pinion

[*Continued from page* 45]

Willmeda W. Johnston, *Doctor's Office Nurse, Burlington, Iowa.*

«(1) All practical nurses should be required to take a home nursing course provided either by a high school or some civic group affiliated with an accredited hospital. This course should have an especially qualified instructor, preferably an R.N., and should be followed by a minimum of three months' clinical training period in said hospital.

«(2) There is definitely a need for practical nurses, and I agree that they should be trained in ratio of two to one. I believe that the cost of educational training for the R.N. as well as the time element involved is far greater than that of the practical nurse; therefore, the R.N. should be held in reserve for the more highly specialized fields. The essential routine duties of nursing could be carried out just as efficiently by the better trained practical nurse whose training is neither so costly nor so lengthy as that of the R.N.

«(3) The ANA should promote legislation for Federal aid to practical nurse education because this action would be an economical and efficient step toward improving the general health of the nation.»

The Children's Physician

[*Continued from page* 43]

Streptomycin when used alone is seriously limited in its capacity to cure H. influenzae meningitis because of emergence of resistant bacterial strains, but it has certain advantages over the antiserum in that it is cheaper and does not produce serum sickness. Since it has not been possible to demonstrate a significant difference in the efficacy of specific rabbit antiserum and sulfadiazine and the combined action of streptomycin and sulfadiazine, one must choose between the expense of the serum and the toxicity of streptomycin. Recent experimental work, however, has led to the use of smaller doses of streptomycin for shorter periods of time, and this method of dosage promises to eliminate one of its most frequent neurotoxic effects—loss of vestibular function.

Once under medical care, the child is given a spinal puncture to determine the causative organisms in the cerebrospinal fluid. When the bacteria are numerous enough to be seen on a stained smear, diagnosis of H. influenzae and its type can be made within 5 to 30 minutes. This is possible in the majority of patients; in the others, diagnosis must await the results of laboratory culture. Treatment by sulfonamides, antiserum, streptomycin or all three in conjunction are given according to the severity of the attack and the judgment of the attending physician. At present there is some disagreement about the most effective route of administration of streptomycin and whether frequent intrathecal injections are really necessary.* The factual data are inadequate for answering this question, but recent evidence suggests that one intrathecal treatment is sufficient.

Early application of treatment is of paramount importance; 24 hours may mean the difference between life and death. The symptoms are similar to those shown in other types of meningitis. The onset may be dramatic or follow an apparently mild respiratory infection. Common symptoms are: fever, vomiting, convulsions, pain in the back, legs and neck. Because of the rigidity of the neck and

JAMA, Feb. 28, 1948. p. 597.

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back the child may assume a position of opisthotonos. Periods of fretfulness alternate with drowsiness and, if the disease is severe, the child may relapse into coma. Kernig's sign, shown by reflex contraction and pain in the hamstring muscles on extension of the legs, is a common symptom. A bulging fontanel in the infant is a danger sign. Complications that may occur after a siege of meningitis are: hydrocephalus, deafness, paraplegia or cerebral deterioration. These conditions have become more frequent in patients who survive as a result of streptomycin, serum and sulfadiazine therapy. In other words, most patients whose brains were severely damaged when treatment with serum and sulfadiazine was started used to die. Now with the addition of streptomycin, a greater number of these patients are surviving but with some residual damage.

Today, thanks to the work of such indefatigable research workers as Dr. Alexander, it is possible to cure completely 100 per cent of patients with influenzal meningitis when adequate treatment is applied early.

It is conservatively estimated that time lost from work because of the common cold is one day per employee per year—or more than 60 million days lost in industry—a wage loss of $420 million yearly. The amount spent on medical care and drugs for treatment of colds by the average family is estimated at $10, or a national total of $400 million. The cold outnumbers any other disease 25-1

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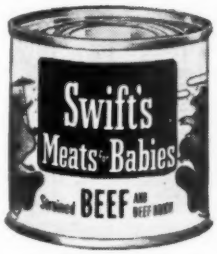

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For patients who can take foods of less fine consistency—Swift's Diced Meats offer tender morsels of nutritious meats with tempting flavors patients appreciate.

Alcoholics Anonymous

[*Continued from page* 50]

it alone." To bring him to see himself as he truly is, is extremely delicate and difficult.

No simple or fool-proof prescription is known. An alcoholic who has been "dried up" for over twenty years and knows fully whereof he speaks asserted that there seems no other way for most alcoholics to recognize their state than to go slowly but surely down hill until they have hit the bottom. Then, when they've lost everything, they'll wake up some day and realize how sick they are and how desperately they need help.

This opinion agrees with the testimony of other experienced workers among alcoholics. On the other hand, there are instances where suggestions coming from a trial judge or a physician or clergyman have sent alcoholics to Alcoholics Anonymous and to clinics with very satisfactory results. There would seem, then, to be a chance in some instances that a nurse might be able to bring a patient to realize his alcoholism. If there is such a chance, slim as it may be, the nurse should seize it and make the best of it rather than take a do-nothing attitude on the assumption that nothing can be done.

So much is expected of nurses today that one wonders whether too much is not being asked of human beings who happen to be registered nurses. Their medical and nursing knowledge and skill are assumed. But in addition, some would have the nurse a social worker, a civic leader,

something of a psychologist if not a psychiatrist, a woman of professional standing with poise and broad culture, a citizen sensitive to local, national and international problems and movements. In one way or another the nurse is supposed by some to be all these things even as she goes about trying to help the sick get well and to keep the well from getting sick.

I have no intention of adding to this growing and formidable list. I want merely to call attention to an organization whose sole purpose is to help sick men and women get better. This is the objective of nursing also. But it would be faulty logic to identify nursing with the work of Alcoholics Anonymous, even though they do share a certain oneness of purpose.

The nurse is not being asked to undertake therapy or in any way to play the role of physician or psychiatrist or social worker or religious guide or Alcoholics Anonymous member. But she stands committed to her patient's welfare; that is certain. And if she discovers he is an alcoholic, it would appear that she is duty bound to do what she can to have him realize it and seek help.

Once she has won the alcoholic to admit his condition and to want to live without alcohol's dubious cushioning, then she can suggest Alcoholics Anonymous. Where there are organizations such as the Yale Clinics or other alcoholic clinics, these too may be mentioned. If the emphasis here is on Alcoholics Anonymous it is not to imply the superiority of its therapy or to underestimate the value

of the public health clinics which are appearing, but as yet are few. The reason is all on the practical side. Some branch of Alcoholics Anonymous is as near as the telephone. If the local community has no group, there is almost certainly one in the nearest city. Alcoholics Anonymous is listed in telephone directories and once an alcoholic applies, I have found distance no obstacle to the zeal of A.A. in replying to his request immediately.

If the nurse is to prove helpful in guiding the alcoholic to treatment, she should not only know those things about alcoholism explained here, but she should know something of the work of the A.A. When an alcoholic applies or is referred to the group by someone, he or she is visited by a member of the group, an ex-alcoholic who can understand from personal experience just how helpless the victim is in the face of his enemy. It is in this rapport, this sense of kinship, that the ex-alcoholic has an advantage over well-meaning friends who can do little because the alcoholic feels they cannot know what he is going through.

The A.A. member then takes the app'icant to a meeting and there he meets other men and women who have had experiences identical with his own. At these meetings, experiences and problems are discussed and the new member becomes aware of the fact that he is not alone in his trouble. Here are respectable citizens who have endured the same tortures and have emerged, not unscathed, but triumphant. [*Turn the page*]


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CANCO

Each new member reads the book *Alcoholics Anonymous* and through that reading and the group discussions learns the 12 steps which are the basis of the A.A. program. Briefly stated, these include: admission of alcoholism, personality analysis and catharsis, adjustment of personal relations, dependence upon some higher power, and working with other alcoholics.

The spiritual aspect of this program is its outstanding feature. The alcoholic may not believe in God *per se*, but he can usually believe in some power greater than himself calling it by whatever name he chooses. It is to this power that he leaves all decisions he must make. If he can bring himself to turn his problem over to this power, the second step has been taken. (The first step was taken at the moment he admitted that he was an alcoholic.)

Catharsis or confession of the wrongs he has done must be made. This includes admitting the wrongs to himself, to God and to another human being. The latter may be a priest or a minister, or it may be a member of Alcoholics Anonymous. Then he must make amends wherever possible to those whom he has wronged. Finally, he must help other alcoholics. It is in this final step that the spiritual values are again uppermost, for with true missionary zeal inspired by love of God and their neighbor, A.A. members spend hours working with those who need them. This is the source of their great and growing strength, for thereby they not only help others, but in so

doing, re-arm their own defenses.

Statistics eloquently record the success of Alcoholics Anonymous; so much so, that there is a temptation to think it automatic or as infallible as the effects of drugs. It is no such thing; Alcoholics Anonymous is not something as physical or inexorable as chemical compounds. Just as alcoholism involves human beings of great complexity, so does sobriety involve this mysterious and often paradoxical composite called man. The outcome is almost exclusively in the patient's hands. It depends largely upon his grasp of the program in its entirety and upon his faithfulness in living it. There are no short cuts and cheating simply boomerangs.

Once in Alcoholics Anonymous or in some alcoholic clinic, the compulsive drinker should be left to expert guidance. Those who have brought him to seek help may prove their interest by showing themselves sympathetic and friendly. The nurse who has played a part in this initial and absolutely essential step has made a major contribution to the salvation of a fellow human being. It may not come suddenly nor in an unbroken career of sobriety. For alcoholics, like all struggling men and women, are not likely to achieve their goal without some stumbling and maybe an occasional fall.

Portal House, Chicago's Treatment Center for Alcoholics, has more than paid for itself in six months by rehabilitating 96 out of 102 destitute cases, who ordinarily would be on city relief.

One Emblem?

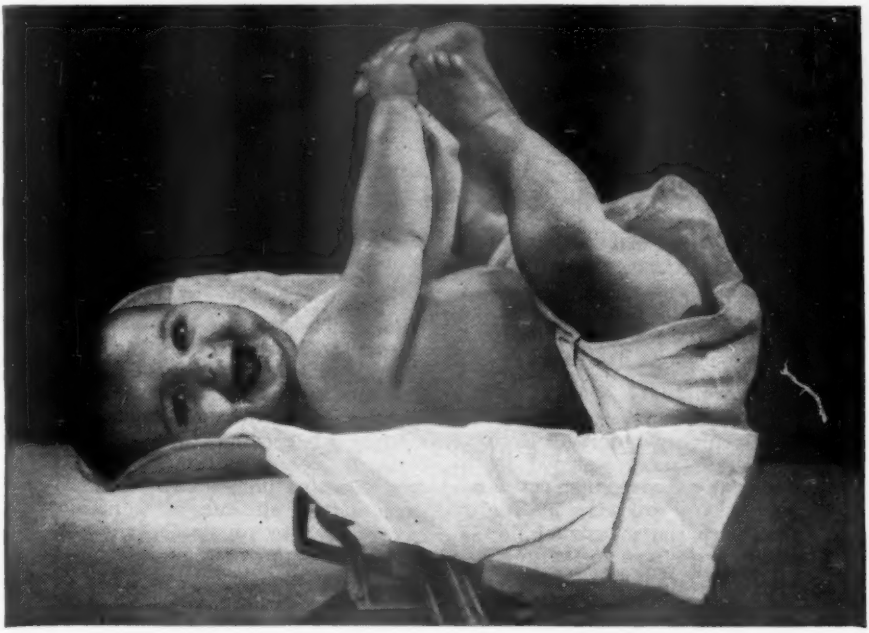
[*Continued from page* 36]

By all means, let us keep the hospital pins; they are our precious individual symbols. And it is advisable for state associations to have their own distinctive "seals." **R.N.** is not advocating elimination, merely urging more cooperative efforts to achieve one significant symbol of the spirit of nursing. Everyone associates the red cross with the Red Cross, the caduceus with the Army Medical Corps, the red feather with the Community Chests and the mortar and pestle with the profession of pharmacy. Wouldn't it be advantageous for the nursing profession to have some such effective design that would serve not only as a visible expression of professional pride but also as a correct means of identification?

The adoption of a national nursing emblem will be an important indication of our professional maturity—the sign of a unified group ready and willing to assume its special responsibilities. Nursing organizations are now in the process of unification. Let's have an emblem study to complement the structure study.

That they had sugar-coated pills in pioneer days for patients who insisted on having them is confirmed in notes left by Dr. Joseph Doddridge who practiced in Western Pennsylvania prior to his death in 1884. "They are harmless substances," he wrote, "which do wonders in all cases in which there is nothing to be done."

5 IMPORTANT REASONS WHY...



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3. Clapp's Method of Pressure Cooking helps retain the natural flavors and colors as well as the vitamins, minerals, proteins and carbohydrates.

4. Clapp's Natural Flavor. Doctors realize the great advantage of Clapp's *natural, true* flavors—in cultivating a child's tastes for adult foods.

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When patients ask you about **tampons . . .**

So that you will know the true facts about Meds, the Modess tampon, Meds has prepared a booklet "It's So Much Easier When You Know," which answers questions like these:

What are Meds?

Meds are small tubes of soft, white, highly absorbent cotton. Meds are safe, designed by a doctor to approved medical standards. They are worn internally to absorb the menstrual flow—thus there is *no odor*—with Meds you stay fresh and clean every day of the month.

How are Meds inserted?

Here's where patients may need your help. Correct insertion is simple, though important. Each Meds comes with its own smooth, glazed sanitary applicator. The outer tube slides easily into the vaginal opening. The inner tube pushes the tampon gently into place above the sphincter muscle, which holds it firmly until it is removed. The improved applicator cannot come apart. Meds are the safest, surest, most comfortable method of sanitary protection ever known.

When can I first use Meds?

Any normal woman, married or single, can use Meds as soon as she is fully grown, when the vaginal opening will admit a tampon without difficulty. Meds come in three sizes, Junior, Regular and Super, to fit individual needs. Some women like the added protection of Meds *and* Modess for the first few days.

The advantages of Meds?

Meds are comfortable. You won't know you're wearing one—*and neither will anyone else.* Meds give you absolute freedom of action, no bother with pins, pads or belts. Meds are the daintiest method of keeping fresh and clean, living a normal life *every* day. Doctors appreciate their psychological advantages. Clinical research by reputable gynecologists has proved their safety. And there's no disposal problem—Meds simply flush away.

So that you will know about Meds yourself, and will be able to tell your patients about this new and better method of sanitary protection, we invite you to send for your free professional sample of Meds in plain wrapper, and Meds' new free educational booklet "It's So Much Easier When You Know." Write today!

Olive Crenning, Special
Representative to the Nursing Profession
Personal Products Corp., Dept. RN5
Milltown, N. J.

Yes, I would like to try Meds and read your educational booklet. Please send samples and booklet to

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Position _____

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POSITIONS AVAILABLE

All notices in Positions Available are now considered paid advertising. The rate per insertion is $5 for the first four printed lines, $1 for each additional line. Estimate six words per line. Copy must be submitted to **R.N.**, *Rutherford, N.J., not later than the 20th of the month preceding publication;* ***remittances must accompany insertion orders.*** *Checks should be made payable to The Nightingale Press, Inc.*

ADMINISTRATOR: Approved 50 bed New York hospital. Pleasant community. Excellent salary. N201 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

ADMINISTRATOR: Approved 40 bed hospital Michigan summer resort area. Prefer nurse with administrative experience. N204 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

ADMINISTRATOR: 40 bed general hospital. Prosperous town of ten thousand adjacent western capital. Minimum $3600 maintenance. N213 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

ADMINISTRATOR: Small sanatorium for pulmonary tuberculosis. Duties principally administrative. Small town located in summer-resort area of East. RN5-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ADMINISTRATOR: General voluntary hospital, 110 beds. Expansion program. Town of 30,000 short distance from university center, East. RN5-1 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

AFTERNOON SUPERVISOR: For clinic-hospital, 48 beds, seaside city near Los Angeles. $250, 40 hour week. Business and Medical Registry (agency), 553 S. Western Ave., Los Angeles, Calif.

ANESTHETIST: New York City suburb. Approved 200 bed hospital. Full maintenance. Attractive salary. Apply United Hospital, Port Chester, N.Y.

ANESTHETIST: New hospital-clinic near Hot Springs National Park. Unusually progressive group. $4800 yearly. N391 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

ANESTHETIST: 70 bed approved hospital near San Francisco, Calif. Pleasant residential community. $4000 yearly. N378 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

ANESTHETIST: New 15 bed hospital near Texas medical center. Modern and well equipped. $4800 yearly. N368 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

ANESTHETISTS: (a) Medical and dental surgery. Oregon. $300. No calls or night work. (b) For approved private hospital, coast city, Southern California. $300. 40 hour week. Business and Medical Registry (agency), 553 S. Western Ave., Los Angeles, Calif.

ANESTHETIST: Good nurse for small general hospital. Beautiful little city situated near Sound. One-hour ride from Seattle. Salary open, depending on experience and references. Apply Providence School of Nursing, Everett, Wash.

ANESTHETIST: Preferably male nurse. Small general hospital. $4200. Middle West. RN5-9 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETIST: General hospital, 380 beds. Active surgical department, four anesthetists. $300, maintenance. Middle West. RN5-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ASSISTANT DIRECTOR OF NURSES: Male or female, well experienced in psychiatric work. 85 bed private mental sanitarium, 35 miles from N.Y.C. Registered or eligible for R.N. in N.Y. Preference given to nurse with degree. Salary dependent on experience and ability. Age between 28 and 40. State full particulars in first letter. Croton Manor Sanitarium, Croton-on-Hudson, N.Y.

ASSOCIATE DIRECTOR OF NURSING EDUCATION: 200 bed approved hospital eastern college town. $4800. Degree and experience. N158 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

BLOOD BANK NURSE: 200 bed Ohio hospital. Registered nurse with blood bank experience to supervise department. $3000 yearly. N297 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

[Turn the page]

CHIEF NURSE: General hospital operated by large industrial company, Arabia. $5400, maintenance. Transportation. RN5-11 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

CLINIC NURSE: Modern 15 room clinic. Southeastern capital. 5½ day week. Training in laboratory and X-ray required. $4800 yearly. T247 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

CLINICAL INSTRUCTOR: Immediate opening in 300 bed general hospital approved school of nursing. Large student body. Experienced R.N. with degree in nursing education required. Salary $250 per month. Vacation and sick leave policy. Write Personnel Director, Aultman Hospital, 625 Clarendon Ave., S.W., Canton 6, Ohio.

CLINICAL INSTRUCTOR: 300 bed approved general hospital adjacent to Cincinnati. $3000 maintenance. N104 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

COMMUNICABLE DISEASE SUPERVISOR: 35 bed unit located on outskirts of beautiful seashore city, southern New England. 44 hour week, paid vacations, 7 full holidays, sick time allowance. Salary open. Address Box JL-1 c/o R.N., Rutherford, N.J.

DIETITIAN: Small private general hospital on ocean near Mexican Border. Delightful climate and surroundings. $225. meals. 40 hour week. Business and Medical Registry (agency), 553 S. Western Ave., Los Angeles, Calif.

DIRECTOR OF NURSES: New hospital, 100 beds, general. All graduate staff. Residential town shert distance from Sacramento and San Francisco. RN5-15 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTOR OF NURSES: Puerto Rico. 100 bed approved hospital on seashore adjacent to Country Club. $3200 maintenance. N505 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

DIRECTOR OF NURSES: Degree and experience required. Modern psychiatric institution near Philadelphia. $4200 maintenance. N509 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

DIRECTOR OF NURSES: 150 bed approved hospital attractively located in northern Florida resort community. $5000 yearly. N461 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

DIRECTOR OF NURSES: Approved 200 bed general hospital Los Angeles area. $350 plus nice furnished apartment. N506 Woodward Medical Bureau, 185 North Wabash, Chicago 1, Ill.

DIRECTOR OF NURSES ASSISTANT: 100 bed approved hospital near Chicago. Consider nurse with general supervisory experience. $3000 maintenance. N148 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

DIRECTOR OF NURSES ASSISTANT: Degree and experience required. 400 bed general hospital. Eastern university town. $3000 maintenance. N143 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

EDUCATIONAL DIRECTOR: 200 bed approved hospital with five year collegiate program. Chicago suburb. $3600 maintenance. N164 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

EDUCATIONAL DIRECTOR: 135 bed hospital, School of Nursing with college affiliation. B.S. desired. Salary open. Two meals and laundry of uniforms furnished. Apply Director of Nurses, General Hospital, Wichita Falls, Tex.

GENERAL DUTY NURSES: Nevada county hospital. Qualified to take responsibility in surgery and delivery rooms along with general duty. $230 with maintenance, increase to $250 in six months, $275 after one year. Business and Medical Registry (agency), 553 S. Western Ave., Los Angeles, Calif.

GENERAL DUTY NURSES: 90 bed modern hospital. Alternating shifts. Additional compensation for evening and night shifts. Vacation with pay and sick benefits. Gross salary $190 minimum. Board available for $7.50 per

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meal per month. Apply Director of Nursing, Miller Memorial Hospital, Duluth, Minn.

GENERAL DUTY NURSES: Several. 200 bed general hospital operated under auspices large industrial company. Excellent living accommodations. Town of 25,000, West. $3380. RN5-23 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSES: 16 bed modern hospital in heart of the Rocky Mountains. $175 7-3 duty, $185 3-11. Two meals, laundry, sick leave, vacation. 14 workdays. Full information if interested. Solandt Memorial Hospital, Hayden, Colo.

GENERAL DUTY NURSES: Several. New hospital. $3700, maintenance provided at $35 monthly. Alaska. RN5-24 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSES: Several. New hospital. $3700, maintenance provided at $35 monthly. Alaska. RN5-24 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL STAFF NURSES: University Hospital, Ann Arbor, Michigan. 5 day, 40 hour week. Hospital day begins at 8:00 a.m. Positions in operating rooms, surgical, medical, neuropsychiatric, and tuberculosis nursing units. All University holidays with pay, 12 days illness allowance yearly and 12 rotating hours of duty $205 per month minimum, $215 maximum. Additional $5 per month for permanent evening or night duty. Promotion to nursing unit administrative positions made from general staff. Room charge $20 per month for nurses desiring to live in nurses' residences. Write Director of Nursing.

GENERAL STAFF NURSES: $170 plus meals. $10 increase every six months for 2 years. 2 weeks vacation. 2 weeks sick leave. Write Hamilton County Public Hospital, Webster City, Iowa.

GRADUATE NURSES: Three. Needed for general duty in small hospital in surgical and obstetrical ward. 3 to 11 shift. 48 hour week. Cash salary $190, $200 after six months. Complete maintenance. Three weeks paid vacation at end of year. Retirement. Apply Supt. Wadsworth Municipal Hospital, Wadsworth, Ohio.

GRADUATE NURSES: 75 bed general hospital, 8 hour shifts, 6 day week, maintenance in beautiful nurses home. Salary $155 per month. Write Dr. Fred V. Shadid, Medical Director, Community Hospital, Elk City, Okla.

HEAD NURSES and GENERAL DUTY NURSES: For 650 bed tuberculosis hospital located 15 miles south of St. Louis. Gross starting salary: head nurses $265 per month; general duty nurses $250 per month; yearly increments granted; full maintenance if desired at $48 per month. 44-hour week, three weeks' annual vacation, 11 holidays a year, accumulative paid sick leave after 60 days' employment. Must be eligible for Missouri registration. Apply Superintendent of Nurses, Robert Koch Hospital, Koch, Mo.

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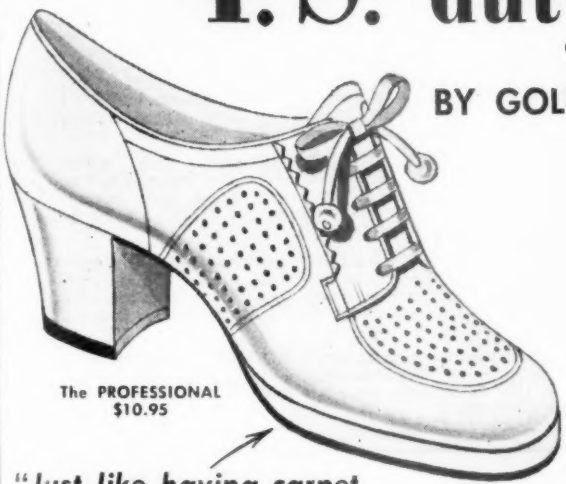

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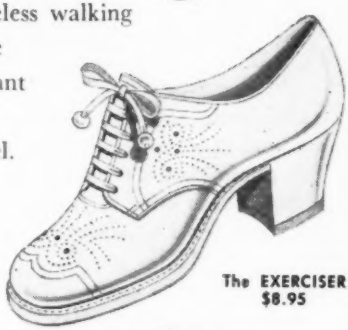

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INSTRUCTORS: Science; and Instructor, Nursing Arts for School of Nursing. B.S. required. For information apply Director of Nurses, Polyclinic Hospital, Harrisburg, Pa.

INSTRUCTOR-PSYCHIATRIC: Psychiatric unit of modern, well-equipped hospital. $400, complete maintenance. Hawaii. RN5-26 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

MALE NURSE: Registered. General hospital operated by large industrial company in tropical country. White and native staff. RN5-30 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill

NURSE ANESTHETIST: For 125 bed hospital, well equipped and fully approved, predominately surgery. Good salary. Apply Administrator, Mid State Baptist Hospital, Nashville, Tenn.

NURSES: One for O.R. Salary open. Four for general duty. $200 a month. Write Mrs. Spears, Dennis Memorial Hospital, Pinewald, N.J.

NURSING ARTS FACULTY VACANCY: Degree and experience for N.L.N.E. Accredited school with college affiliations, in 230 bed, beautifully located, general hospital. 44 hour week. Excellent personnel policies. Maintenance optional. Apply Director School of Nursing, Blodgett Memorial Hospital, Grand Rapids, Mich.

NURSING ARTS INSTRUCTOR: Eastern university hospital. $3900 yearly. Forty hour week. Degree and experience required. N238 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

NURSING ARTS INSTRUCTOR: Now or September 1st. Month's vacation with pay, plus sick leave. Salary open. Apply Directress of Nursing, Lock Haven Hospital, Lock Haven, Pa.

OBSTETRICAL SUPERVISOR: Degree desired. Consider wide experience and postgraduate work. Large New York hospital. $3600 maintenance. N147 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

OBSTETRICAL SUPERVISOR AND INSTRUCTOR: 135 bed hospital with active obstetrical service. Post-graduate work or the equivalent required. Apply General Hospital, Wichita Falls, Tex.

OFFICE ASSISTANT and SURGICAL NURSE: For medical director of 16 bed hospital-clinic. Texas. $2400 maintenance. N296 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

OPERATING ROOM SCRUB NURSE: $155 per month to start plus full maintenance. $5 increase each year for five years. Vacation, sick leave. Apply Princeton Hospital, Princeton, N.J.

OPERATING ROOM SUPERVISOR: To reorganize entire department including teaching program. 300 bed hospital, southern

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New England City. Operating suites being completely renovated. Salary open. Paid vacations, 7 full holidays, sick leave. Apply Box JL-2 c/o R.N., Rutherford, N.J.

OPERATING ROOM SUPERVISOR: New, modern hospital-clinic. Chicago area. Consider experienced scrub nurse. $225 plus quarterly bonus. N248 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

OPERATING ROOM SUPERVISOR: 200 bed approved general hospital southern California. $3200. Must be well qualified. N222 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

PUBLIC HEALTH SUPERVISOR: To conduct generalized nursing program including school health services. City Health Department, Middle West. $4500-$5000. RN5-33 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

REGISTERED NURSES: All services or shifts in 150 bed general hospital. Straight 8-hour, 44-hour week. Vacation and sick leave with pay. Beginning $8 per day, $8.60 per evening or night. Inexpensive rooms in vicinity. Write Director of Nurses, Glenville Hospital, Cleveland 8, Ohio.

SCHOOL NURSE: Public schools, residential town near Chicago. Should be qualified to direct program. RN5-46 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SCIENCE INSTRUCTOR: Large teaching

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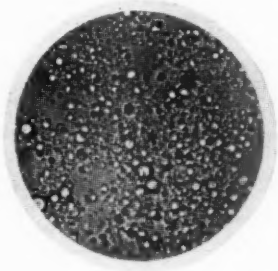
leaving discontinuous film, reduces incidence of miliaria from 55% to 3%

THE IDEAL preparation for infant skin care . . . should it leave a solid layer . . . or a *discontinuous film?*



Recent studies at a Chicago hospital, where various preparations were tested on 2,077 newborn infants, prove that the *lotion* type of preparation (specifically, Lotion "10FA"*), which leaves *a discontinuous* film on the skin, produces decidedly superior results.

As reported in the Amer. Jour. of Diseases of Children (March, 1948) the case incidence of miliaria was reduced from 55% to 3% with the use of Lotion "10FA."*

"This reduction in the occurrence of miliaria appeared to be due to the use of an oil in water emulsion. (Lotion "10FA."*)

"An important advantage accrues from the inherent discontinuous, but protective, film, which does not interfere to any significant degree with the metabolic and respiratory functions of the skin."

Unlike many other preparations, this smooth white Lotion produces no "smothering" effect which interferes with the process of respiration.

This is particularly important in summer, when infants perspire excessively and the rate of miliaria normally increases. Emphasizing the superiority of Lotion "10FA" was the sharp drop in summer incidence of miliaria.

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Limited to nursing profession in U. S. A.

hospital, southeastern university town. Attractive personnel policies. $4000 yearly. N163 Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

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STAFF NURSES: For new, modern 65 bed hospital. 8 hour day. Rotating shifts. Beginning salary $175 per month with full maintenance, increased at three months. New nurses' home. Single rooms with bath. Very mild climate. Apply Superintendent of Nurses, Ritch-Leaphart Hospital, Jesup, Ga.

SUPERINTENDENT OF NURSES: Community hospital, 120 beds. Latin-American population off U.S. mainland. City of 200,000. Graduate and student body. $3200, excellent maintenance. No. U.S. income tax deductions. Mild climate, pleasant social life. Business and Medical Registry (agency), 553 S. Western Avenue, Los Angeles, Calif.

SURGERY NURSE: Progressive small hospital, industrial town suburban to Los Angeles and near ocean. $215, maintenance. 40 hour week. Business and Medical Registry (agency), 553 S. Western Ave., Los Angeles, Calif.

SURGICAL NURSE: Experienced. 43 bed hospital. Salary open. Write Hamilton County Public Hospital, Webster City, Iowa.

You know, you do more for your patient than you might think . . .

For instance, your crisp clean uniform and your air of confident grooming go a long way to brighten your patient's day.

But good grooming is more than the morning bath and a bright fresh uniform. Because perspiration is a continuous process.

Mum is the *safer* way to preserve morning-bath freshness because it contains no harsh or irritating ingredients — stays smooth and creamy — does not dry out in the jar. And Mum is *sure* because it prevents underarm odor throughout the day or evening. Recommend it to your patients too.

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®

A preparation of conjugated estrogenic substances (equine) in a non-greasy base, for use where the absence of oiliness following application is a desirable factor.

... May be found of value in the treatment of senile vulvovaginitis, pruritus vulvae and kraurosis vulvae, particularly when the production of specific local effects is the aim of therapy.

... Also may be found of value in the treatment of hypoplasia of the mammary gland in the hypogenital type of woman when the breast is structurally capable of a growth response.

..."Premarin" Cream No. 871 provides 1.25 mg. of conjugated estrogens (equine) per gram; No. 870, 0.625 mg. per gram. For purposes of dosage measurements, one quarter-teaspoonful (level) delivers one gram of cream. Supplied in jars of 1 and 2 ounces.

Ayerst, McKenna & Harrison Limited
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For

Vitamin Therapy

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Vitamin B_1 (thiamine)	15 mg.
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Vitamin B_6 (pyridoxine)	2 mg.
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Folic acid	5 mg.
Calcium pantothenate	10 mg.
Vitamin C (ascorbic acid)	150 mg.
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High Potency – Therapeutic Formula – Multiple Vitamin Capsules

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